

CLIENT FEEDBACK INTAKE FORM

The Ministry of Health & Wellness aims to provide quality services to its clients and to provide an environment for the staff to provide the best service possible. Sometimes we get it right and other times we don't. This form allows you to let us know how you feel about the services at any of our facilities.

Had a good experience or bad one, have a suggestion to make or just want some assistance? Please let us know!

For Clients: Please complete sections A and B. If you are not able to, please ask the Complaint Handling Officer to assist you. For

	Facility: Please complete sections C, as well as A and B if client is not able to.	
	Day Month Year Hour Minute Time: am/pm	
١.	GENERAL INFORMATION	
	1a. Name of Client: (The Client is the persons who had the experience - If Client is also the person making the report, skip Section 2)	
	Mr. Mrs. Miss Ms. Dr.	
	First Name: Middle Initial:	_
	Surname:	
	1b. Indicate whether the client is: Patient Employee Visitor Relative	
	Other (please specify)	
	1c. Date of Birth: Day Month Year Age:	
	1d. Gender: Male Female	
	1e. Nationality: Jamaican American British Other	_
	2a. Name of Person making the report:	
	Mr. Mrs. Miss Ms. Dr.	
	First Name: Middle Initial:	
	Surname:	
	2b. Your relationship with the Client: Parent/Guardian Relative Spouse Spouse	
	Child Friend Other	
	3a. Client Contact Information:	
	Lot/Apt # & Street Name:	
	District/Landmark:	
	Parish:	
	Email @	
	Phone number(s)	
	3b. Contact No. for person making report: Mobile (8 7 6)	
	Home ()	
	Work ()	
	4 Preferred Redress Apology Compensation Access to service (not for compliments)	
	Explanation of what happened Improvements in procedure/practices/ facility	
RM-C	CMS-SRD-IE-032-R2 V3 Updated March 2023 Page 1 of 3	

В.	DETAILS OF THE CASE					
	Please indicate the <u>health facility/agency</u> and the <u>clinical service/area</u> where the incident occurred:					
	Health Facility/Agency:					
	Clinical Service/Area:					
	Date of complaint event:					
	Please describe with as much detail as possible, the events leading up to your experience. Include dates, the reason for seeing the Health Service Provider, names of staff members or provide a description of the individual e.g. wears a blue and white uniform. Indicate what you want to happen or what action or recommendations you would like to see implemented.					
	Signature of Complainant:					
	Signature of First Receiver (Staff):					

FOR OFFICIAL US	SE ONLY		
Case No.:	- 🗔		
Method of Transmis			
Telephone [E-mail BPO	Letter	Office Visit/ Face to Face
e-form	Social Media	Referral from MOHW	Media Report
Fax	Other (specifiy)		
Type of feedback:			
Complaint (Gen. Assist.	Suggestion	n/Recommendation
Compliment		Other (spe	ecify)
Feedback Classificat	ion: Clinical	Non-clinical	
	Litigious	Non-litigious	Potentially Litigious
Main Category:	Access	Communication	Decision Making
Costs Right	ts, Respect and Dignity	Grievances	Corporate Services
Professional Conduct	Quality of Clin	ical Care	Other
Sub Category:			
Chatana C C			
Status of Case:	\neg		
Received	Date	Acknowled	dged Date
Investigation started	Date	Referred	Date:
Submitted for review	Date	Escalated Further M	
Arab de .			
Vithdrawn	Date		Date
Case Outcome Uphe	eld Not Upheld	Partially Uphe	eld Undecided
Standard Care/ Procedur	re Followed Subst	andard Care/ Procedure bre	eached Undecided
Client Status:	Satisfied Diss	satisfied	Undecided
Cheffit Status	DISS	acioned	Ondecided
Cause Identification Root Cause			
Causal Factors			
- Causai i dettuis			
Corrective Action Requir	r ed (Please indicate any action r	equired to remedy the situa	tion and to prevent a recurrence of the issue)
		Complet	red by:
		Name:	
		Date:	Day Month Year
VIS-SRD-IE-032-R2	V3 Updated March 20	23	Day Month Year Page 1 of 3

	DETAILS OF THE CASE (CONT D)
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	Signature of Complainant:
	Signature of First Receiver (Staff):