MINISTRY OF HEALTH & WELLNESS

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.

Date: *Day* *Month* *Year* ☐☐☐☐☐☐☐☐ **Time:** *Hour* *Minute* ☐☐☐☐ am/pm

A. 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 ☐

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 *(not for compliments)* Apology ☐ Compensation ☐ Access to service ☐

Explanation of what happened ☐ Improvements in procedure/practices/ facility ☐

B. DETAILS OF THE CASE

Please indicate the *health facility/agency* and the *clinical service/area* 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):

C. FOR OFFICIAL USE ONLY

Case No.: ☐☐☐☐ - ☐☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐☐

Method of Transmission:

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/Recommendation ☐

Compliment ☐ Other (*specify*) ☐ _____

Feedback Classification: Clinical ☐ Non-clinical ☐

Litigious ☐ Non-litigious ☐ Potentially Litigious ☐

Main Category: Access ☐ Communication ☐ Decision Making ☐

Costs ☐ Rights, Respect and Dignity ☐ Grievances ☐ Corporate Services ☐

Professional Conduct ☐ Quality of Clinical Care ☐ Other ☐

Sub Category: _____

_____

Status of Case:

Received ☐ Date _____ Acknowledged ☐ Date _____

Investigation started ☐ Date _____ Referred ☐ Date: _____

Submitted for review ☐ Date _____ Escalated for Further Mgnt. ☐ Date: _____

Withdrawn ☐ Date _____ Closed/ Resolved ☐ Date _____

Case Outcome Upheld ☐ Not Upheld ☐ Partially Upheld ☐ Undecided ☐

Standard Care/ Procedure Followed ☐ Substandard Care/ Procedure breached ☐ Undecided ☐

Client Status: Satisfied ☐ Dissatisfied ☐ Undecided ☐

Cause Identification

Root Cause _____

Causal Factors _____

_____

Corrective Action Required *(Please indicate any action required to remedy the situation and to prevent a recurrence of the issue)*

Completed by:

Name: _____

Date: ☐☐ ☐☐ ☐☐☐☐

Day Month Year

B. DETAILS OF THE CASE (CONT'D)

Signature of Complainant: _____

Signature of First Receiver (Staff): _____