YOUR EXPECTATIONS

SIGNATURE OF USER OR USER'S REPRSENTATIVE, IF APPLICABLE :

DATE :

FORWARD YOUR FORM BY MAIL OR EMAIL

Ombudsman - complaints and quality services,
CHU Sainte-Justine, Room A921
3175, Côte-Sainte-Catherine
Montréal (Québec) H3T 1C5
Phone : (514) 345-4749
Fax : (514) 345-7720

commissaire.message.hsj@ssss.gouv.qc.ca

ASSISTANCE AND SUPPORT :

· CHU Sainte-Justine Users' Committee :
514 345-4931, ext. 5902

· Your local Centre d'assistance
et d'accompagnement aux plaintes (CAAP).

1 877 767-2227

For additional information on the complaint examination system or on your rights under the Act respecting health services and social services, please visit the Ministère de la Santé et des Services Sociaux Website at http://sante.gouv.qc.ca/en/systeme-sante-en-bref/plaintes/

chusj.org

COMPLAINT AND POSITIVE FEEDBACK FORM

LOCAL SERVICE QUALITY AND COMPLAINTS COMMISSIONER

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Université de Montréal

Centre de réadaptation Marie Enfant
CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Université de Montréal

IDENTIFICATION OF USER (PATIENT/RESIDENT)

The personal information provided is confidential

First name and last name: _____

_____

Full address: _____

_____

_____

Phone (between 8:30 am and 4:30 pm): _____

Cell phone: _____

Date of birth: _____

File numbe (if avalable): _____

Room number (if avalable): _____

IDENTIFICATION OF THE USER'S REPRESENTATIVE, IF APPLICABLE

First name: _____

Last name: _____

Full address: _____

_____

_____

Phone (between 8:30 am and 4:30 pm): _____

Cell phone: _____

Relationship with user:
Parent : ☐ Legal representative: ☐

Other (specify): _____

DESCRIBE THE EVENT

N.B.: If you have documents that could be useful in processing your complaint, please provide them with this form. Please write your name on each document.

DESCRIBE THE EVENT (CONT.)

Date and time of the event