



REVIEW REQUEST

The Patient Care Quality Review Boards have legal authority to review a care quality complaint that has been addressed by a health authority's Patient Care Quality Office but remains unresolved. If you have not submitted this complaint to a Patient Care Quality Office, you must complete that process before submitting a review request form. For more information, please visit www.patientcarequalityreviewboard.ca

If you need assistance completing this form, please call 1 866 952-2448.

Name of the individual who received the care or service		Date of Birth (YYYY / MM / DD)
Personal Health (BC Services Card) Number	Primary Phone Number	Secondary Phone Number
Full Address and Postal Code		

Dates of Care/Service (YYYY / MM / DD)

Where or in which facility (e.g., hospital) did the incident(s) occur?

What is the nature/description of the complaint (i.e., what happened)?

Name of Patient Care Quality Office that received your complaint	Date Complaint Filed (YYYY / MM / DD)
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What was the Patient Care Quality's Office's response to the complaint? (If you received a written response, please attach a copy.)

What is the reason you are not satisfied with the Patient Care Quality Office's response to the complaint?

What outcome or resolution are you seeking through the review process?	
Have you registered the complaint with another agency (e.g., the College of Physicians of BC or the Ombudsperson)?	
Please provide any additional information you would like the review board to consider.	
Where did you hear about us?	Email Address (if you would like us to communicate with you through email)

AUTHORIZATION

The personal information requested on this form and any additional information required by a Patient Care Quality Review Board in reviewing the care quality complaint submitted by or on behalf of an individual is collected under the authority of the *Patient Care Quality Review Board Act* and the *Freedom of Information and Protection of Privacy Act*, and will be used only for the purpose of reviewing this complaint. All persons obtaining personal information under the *Patient Care Quality Review Board Act* are under a duty of confidentiality with respect to that information. If you have any questions about the collection, use or disclosure of this information please contact the Patient Care Quality Review Board Secretariat at the telephone number, fax number or mailing address set out at the bottom of this form. The authorization you complete below becomes effective on the date this form is submitted and remains in effect until the review is completed.

Please make the applicable selection below by placing an “X” in the box beside it:

- By making this selection I confirm that I am the individual named at the top of this form and to whom the review request relates, and that I am submitting this request for a review of the complaint described above, by a Patient Quality Review Board.
- By making this selection I confirm that I am a person authorized under the common law or legislation to make health care decisions regarding the individual named at the top of this form, and I am submitting this request for a review of the complaint described above, by a Patient Care Quality Review Board.
- By making this selection I confirm that I have the consent of the individual named at the top of this form to submit the complaint described above on his or her behalf, for review by a Patient Care Quality Review Board. **If you make this selection, you must include a Third Party Consent Form (HLTH 2041) completed by the person giving the consent.**
- By making this selection I confirm that I have the consent of the person authorized under the common law or legislation to make health care decisions regarding the individual named at the top of this form to submit the complaint described above on his or her behalf, for review by a Patient Care Quality Review Board. **If you make this selection, you must include a Third Party Consent Form (HLTH 2041) completed by the person giving the consent.**

IMPORTANT NOTE IF YOU ARE SUBMITTING THIS COMPLAINT ON BEHALF OF SOMEONE ELSE

If you are not submitting this complaint on your own behalf, please be advised that only a person to whom the health care or service was (or was not) delivered, someone authorized by such a person, or a person authorized under the common law or legislation to make a health care decision on behalf of such a person, may submit a care quality complaint. If you are submitting this complaint on behalf of another person please complete the following:

Your Name	Relationship to Patient (e.g., parent, spouse)	Phone Number
Full Address with Postal Code		

Signature

Date Signed (YYYY / MM / DD)

Patient Care Quality Review Boards, PO Box 9643, Victoria, BC V8W 9P1

Phone: 1 866 952-2448 Fax: 250 952-2428