



AODA Compliance Document – TOH Record of Accessibility Feedback

Feedback Given To: _____

Date Feedback Received: _____

Name of Patient (Optional): _____

Issue Identified:

1. Patient/Family/Complainant has received a response from TOH: Yes No

2. Forward to the appropriate person/department within the organization:

Quality & Patient Safety _____

Risk Management _____

Patient Advocacy _____

Communications _____

Facilities Management _____

Clinical Directors/Managers/Staff _____

Information Services _____

Volunteers _____

Senior Administration _____

Other _____

3. Summary of Actions Taken: _____
