COMPLAINT FORM

Please refer to the Complaints Leaflet for further information on our Complaint Procedure

Please use block capitals to complete this form

Complainant's (Your) details:

Name: ……

Date of Birth: ……

Address: ……

Contact telephone number: ……

Patient's details (if different from above):

Name: ……

Date of Birth: ……

Address: ……

Contact telephone number: ……

Summary of complaint: (include dates, times, places and names of practice staff involved plus a full description of events – continue overleaf if necessary)

Please see overleaf

What would you like to happen as a result of your complaint?

Complainant's signature: …… Date ……

If you are making a complaint on behalf of someone else, please ensure they complete and sign the section below <u>before</u> you submit the complaint to the practice:

I fully consent to my Doctor or other practice staff releasing information to, and discussing my care and medical records with the person named above in relation to this complaint, and I wish this person to complain on my behalf.

This authority is for an indefinite period / for a limited period only (**delete as appropriate**)

Where a limited period applies, this authority is valid until…….. (**insert date**)

Signed: ……. (Patient only)

Date: ……..