**COMPLAINT FORM**

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Address |  |
| Phone Number |  |

|  |
| --- |
| **Summary of the complaint, please give as much information as possible:**  What happened?  Who was involved?  When did it happen?  Where did it happen?  How did it happen?  Why did it happen?  What is your desired outcome?  Any other information?  *Continue overleaf if necessary…* |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | Date |  |

***Anonymous Complaints:***In the interest of fairness we cannot investigate anonymous complaints.

***Note:*** If you are complaining on behalf of a patient or your complaint or enquiry involves the medical care of a patient then the consent of the patient will be required. Please obtain the patient’s signed consent below.

**COMPLAINT FORM – PATIENT THIRD PARTY CONSENT**

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Address |  |
| Phone Number |  |

|  |  |
| --- | --- |
| Complainant’s Name |  |
| Relationship to Patient |  |
| Address |  |
| Phone Number |  |

I fully consent to my doctor releasing information to, and discussing my care and medical records with the person named above in relation to this complaint only, 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: