JRB Healthcare

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Web: https://jrbhealthcare.co.uk

Principle GP: Dr Chaitra Hodegere

COMPLAINTS FORM

Complaint Details

Please include as much detail as possible, including times and names of individuals if known

Please continue on a second sheet if necessary

About the patient

Patient Name:

Patient Address:

Telephone number:

Are you : ☐ The patient ☐ The Patients representative, if so what if your name and relationship to the patient

Patient Signature Date

Third party consent: complete if someone is complaining on your behalf

If you are complaining on behalf of the patient, we require their written consent in order to be able to discuss their care with you. Without this consent we will investigate your concerns but will not normally be able to provide any feedback to you once the in investigation is completed. If you are complaining on behalf of a patient for whom you hold a Lasting Power of Attorney (Health and Social Care) and the Practice has a copy of this document please tick here ☐ and return this form to the Practice. Otherwise the patient should complete the following declaration.

I (insert full name of patient) consent to information about my care and treatment, relevant to this complaint, being shared with my representative

Patient Signature Date

Consent to contact third parties: complete if your complaint involves other providers

Sometimes complaints can involve multiple service / care providers. If you feel this may be the case with your complaint, please provide details of other providers you feel we may need to involve in investigating your consent.

Please Note: if your complaint is found to relate exclusively to one of these organisations we may request that the complaint be passed to them in order to investigate and respond. Additionally, where complaints are complex and involve multiple care providers we may ask the local Clinical Commissioning Group to identify a single organisation to lead on the investigation and respond to you.
Please sign below to confirm that you consent to us sharing information about your complaint in this way for the purposes of investigating and responding to your complaint.

Patient Signature Date

Practice use only

Managed concern within 24 hours ☐

Date received:

Acknowledgement Sent:

Sent by:

Investigator: