LISTER MEDICAL CENTRE

contact.lister@nhs.net

COMPLAINTS

DATE: ………………………………………………… **DOB:** …………………………………

PATIENT NAME: ………………………………………………………………………………

PATIENT ADDRESS: ……………………………..…………………………………………..

COMPLAINANT: ………………………………………………………………………………

DOCTORS NAME: ……………………………………………………………………………

RECEPTIONIST'S NAME: ……………………………………………………………………

IF YOU ARE COMPLETING THIS FORM ON BEHALF OF SOMEONE ELSE, THEY MUST SIGN BELOW TO GIVE CONSENT

PATIENT SIGNATURE: ……………………………………………………………………..

REASON FOR COMPLAINT:

RECEPTION/TELEPHONE/ADMINISTRATION/DOCTOR (delete as necessary)

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ACTION TAKEN: ……………………………………………………………………………………

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Please return your completed form to reception or send it to the email address above.