



Complaints Form

(to be completed by patient/complainant)

TO WHICH SURGERY DOES THE COMPLAINT REFER: (ACS, WHC OR BGS):

COMPLAINANT'S DETAILS:

PATIENT'S DETAILS (if different
from complainant):

NAME: -----

NAME: -----

ADDRESS: -----

ADDRESS: -----

TEL: -----

TEL: -----

SUMMARY OF COMPLAINT:

DATE OF OCCURRENCE: -----

SIGNATURE OF COMPLAINANT: -----

DATE: -----

ROUTE OF COMPLAINT: Phone/Desk/Team Member

DATE: ----- APPROX. TIME: -----

MEMBERS OF STAFF/DOCTOR INVOLVED: -----

TYPE OF CONTACT: -----

METHOD OF RESPONSE + BY WHOM: -----

DATE AUDITED: -----

ANY FOLLOW-UP NEEDED? Yes/No

This section to be completed when the complainant is not the patient

I (please give patient's full name) -----

hereby authorise the above complaint to be made and that (please insert complainant's name below)

is acting on my instructions.

PATIENT'S SIGNATURE: -----

DATE: -----