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| --- | --- | --- |
|  |  | **Rushall Medical Centre** |
|  | **Tel : 01922 622212 Email: clinicalinfo.m91019@nhs.net** |
|  | **107 Lichfield Road, Rushall, Walsall, WS4 1HB****Pelsall Village Centre, High Street, Pelsall, Walsall, WS3 4LX** |

# **COMPLAINT FORM**

## We are sorry that you are not entirely satisfied with the service that you have received at Rushall Medical Centre. Please complete this form with as many details as possible about your concerns – we will respond to you as soon as possible and try to resolve the issue.

|  |
| --- |
| **Your Details**  |
| **Name**  |  |
| **Address** |  |
| **Post code**  |  |
| **Date of Birth**  |  |

|  |
| --- |
| **Contact Details**  |
| **Home telephone** |  |
| **Mobile telephone**  |  |
| **Email address** |  |

|  |  |
| --- | --- |
| **Signature - *Complainant*** |  |
| **Date** |  |

|  |
| --- |
| **Patients Details (*if different from above)***  |
| **Name**  |  |
| **Address** |  |
| **Post code**  |  |
| **Date of Birth**  |  |
| **Age of patient**  |  |

I acknowledge and agree that in order for the practice to respond to the complaint

that information in my medical records will be disclosed to those persons named on this form, but only so far as is necessary to answer the complaint.

|  |  |
| --- | --- |
| **Signature – *Patient***  |  |
| **Date** |  |

|  |
| --- |
| **Details of Complaint**  |
| **Date of the event**  |  |
| **Reason for complaint** |  |
| **Name(s) of persons involved**  |  |
| ***Please continue on a separate page if necessary…*** |

|  |
| --- |
| **Office use Only** |
| Date received  |  |
| Date of Acknowledgement – *3 working days*  |  |
| Date of Response  |  |
| Multi-disciplinary meeting date |  |
| Complaint Upheld – Yes / No / Partially |  |