The Gold Street Surgery

Gold Street, Saffron Walden
Branch Surgery: School Street, Great Chesterford CB10 1NN
www.thegoldstreetsurgery.co.uk

Complaint/Concern/Feedback Form

We welcome all suggestions and comments on the services provided by the Practice.

Are you completing this form as (please tick):

Complaint	Concern	Feedback
☐	☐	☐

- We endeavour to give our patients the best care and attention possible.
- We regularly review our service and complaints/suggestions allow us to see areas in which we can improve.
- We are continually looking to turn our patients' feedback into real improvements in the services we provide.
- We use it to focus on the things that matter most to our patients, carers and families.
- We would like to hear from you if you have a suggestion or comment on how we can do things better to improve our patient's experiences.
- We would also like to hear from you if you are pleased with the service you have received. We will let the staff involved know and share the good practice across the team.

If you are completing this form as a complaint, please see our website www.goldstreetsurgery.co.uk for our policy and how we will process the complaint. If you cannot access the website, please ask at reception and we can give you a hardcopy of the policy.

Third party access form is attached if you are completing this form on behalf of a patient, please ensure this is signed and returned to us.

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Please hand this form in at Reception for the attention of Zoie Mathie, Patient Experience Champion, post to the address above or email to goldstsw.feedback@nhs.net.

Patient full name:	
Date of birth:	
Address:	
Complaint details - include dates, times and staff names, if known:	
…… …… …… …… …… …… …… …… …… …… …… …… …… (Continue on a separate sheet if necessary)	
Date completing the form:	
Print Name:	
Signature:	

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PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

_____

ENQUIRER / COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

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. WE CANNOT FEED BACK TO YOU WITHOUT A VALID CONSENT

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, 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: ……..