



Complaint Form

Patient details		
Name		
Address		
Phone no:	Home	Work
If you are complaining on behalf of someone else:		
Your name:		
Your relationship to patient:		
Is the patient aware that you are complaining on his/her behalf <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is someone representing you (e.g. solicitor, advocate) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of your representative:		
Organisation:		
Postal address:		
Phone no:		
What happened?		
Describe the event that you want us to know about. Please give all the dates and details that you can remember.		
What happened?		
Where did it happen?		
Date:	Time:	
Name of anyone who witnessed it:		

What is your complaint about? (person/process/service)

Is there anything else that you want to tell us?

What do you want to happen as a result of this complaint?

Have you tried to resolve your complaint in any other way? (for example, by obtaining a second medical opinion). If so, please give details.