LEISTON SURGERY

PATIENT COMPLAINT FORM

Complainant's details:

Name _____ Date of Birth _____

Address _____

_____

Telephone number _____

Patient's details (if different from above)

Name _____ Date of Birth _____

Address _____

_____

Details of Complaint

Please give a full description of events, the facts and circumstances giving rise to your complaint including dates/times and names of any persons involved if known. Feel free to attach any extra paper required to provide detail.

Complainants Signature _____ Date _____

Where the complainant is NOT the patient

I _____ hereby authorise the above complaint to be made and agree that members of the practice staff may disclose (in so far only as it is necessary to do so to answer the complaint) confidential information about me which I provided to them.

Patients Signature _____ Date _____

This form will be passed to the Practice Manger for investigation and response