HOON HAY MEDICAL CENTRE – COMPLAINT FORM

Date of complaint: ___ / _____ / 20 ____

If you feel we have not provided you with the service you expect from our Medical Centre, please use this form to help us to identify and address your concerns.

PART A: Patient Details

Name: .....

Address: .....

Contact: Please provide your contact telephone number/s or email as our Complaints Officer may contact you during working hours.

Phone/Email: .....

If you are complaining on behalf of someone else:

Your name: .....

Your relationship to the patient (named above): .....

Is the patient aware that you are complaining on their behalf? YES / NO

If someone is representing you (e.g. solicitor or advocate):

Name of your representative: .....

Organisation: .....

Postal address: .....

Telephone number: .....

PART B: What Happened

Describe the event that you want us to know about. Please give all the dates and details you can remember.

What Happened?

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When and where did it happen?

Date: .....

Location: .....

Did anyone witness what happened?.....

What is your complaint about eg it could be about a person, process or service?

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What would you like to happen as a result of making this complaint?

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

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Thank you for taking the time to complete this form. In line with our Complaints Procedure, our Complaints Officer will contact you within five working days of receiving your complaint.