Date Submitted: ____/____/____

alma street MEDICAL

PATIENT COMPLAINT FORM

Title: Mr / Mrs / Miss / Ms / Dr Date of Birth: ____/____/_____

Surname: _____ Given Names: _____

Address _____

Phone (home) _____(work) _____Mobile _____

Email: _____Preferred contact method: ☐ Home ☐ Work ☐ Mobile ☐ Email

I am lodging this complaint on behalf of: (please circle) **Myself** OR **Another person**

If lodging a complaint on behalf of another person, please complete as much detail in the section below.

Details of person who received the service:

Title: Mr / Mrs / Miss / Ms / Dr Date of Birth: ____/____/_____

Surname: _____ Given Names: _____

Address _____

Phone (home) _____ (work) _____Mobile _____

Email: _____

I wish to complain about:(please circle all relevant) Doctor / Nurse / Receptionist / Facilities / Other

My complaint is: (provide a short description – include what happened, when it happened and who was involved, ect)

_____

_____

_____

The main issues I am concerned about are:

_____

_____

_____

What action would you have us take to resolve this

issue?_____

_____

_____

_____

PLEASE PLACE THIS FORM IN THE BOX PROVIDED. THE PRACTICE MANAGER WILL CONTACT YOU WITHIN 48 HOURS TO DISCUSS YOUR COMPLAINT.