

**Patient Complaint Form**

Patient’s name .......................................................................................Date of Birth....................................

Address.................................................................................................................................................................

.......................................................................................................................Post Code.......................................

Telephone Number .......................................................................................GMS Number.................................

Complaint details: (Include dates, times and names of personnel, if known)

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Complaint details: (Include dates, times and names of personnel, if known)

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Signed................................................................................................................ Date..............................



**COMPLAINT FORM WITH PATIENT THIRD PARTY CONSENT**

Patient’s name ..................................................................................................Date of Birth............................

Address....................................................................................................................................................................

................................................................................................................................ Post Code...............................

Telephone Number.................................................................................................................................................

Enquirer/ Complainant’s name .........................................................................................................

Relationship to Patient ............................................................................................................................

Address ...................................................................................................................................................

......................................................................................................................Post Code...........................

Telephone Number .................................................................................................................................

**If you are making a complaint for a patient, or if your complaint / query is about a patient’s medical care, then we need consent from the patient. Please obtain the patient’s signed consent below.**

I consent to my doctor releasing information to, and discussing my care and medical records with the person named above in relation to this complaint only, and I wish this person to complain on my behalf.

Signed: …………………………………………………………………………………………………….................... (Patient only)

Date: …………………………………………………………………………………………………………………….........