Grove Medical Practice  ******

## Doctor Stephen Patton

Doctor Marie Louise Thornton

Doctor Fionnuala Dickson

**COMPLAINTS FORM**

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| Sheet 1 of 2 **PROBLEM / SUGGESTION REPORT FORM** From:  Signed: Date: / / Please return this form marked **‘Personal in Confidence’ to the Practice Manager** |
| Name of person reporting problem/suggestion:  Address:  Tel:  Name of person experiencing problem*(if different from above):*  Address:  Tel: |
| Please describe in one or two sentences the issues that have led to this complaint. This will help us understand the key problems that you have experiences: |
| Has this problem occurred previously? YES / NO |
| Please can you identify where the issue may have arisen? For example, did this happen as a result of conflicting messages, a personality conflict, a problem with communication within the surgery etc. |
| Are you looking for a specific outcome from this complaint? Common outcomes that help us improve our service including training, improved communication, looking at ways to work differently, or by simply apologising where your experience has not been as you had wished. |
| We would like to review this complaint as part of our Complaints Procedure to ensure our systems are as efficient as we can make them.  Are you happy for us to review things going forward? YES / NO |
| Official Use Only Date matter arose: / / Date matter reported to the Practice: / / How was the situation left / action taken: |

**AGREEMENT FOR A REPESENTATIVE TO ACT**

**ON BEHALF OF THE COMPLAINANT**

*(To be completed by the patient where the complainant is not the patient)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the complaint set out overleaf

to be made on my behalf by *(name):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of *(address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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I agree that the practice may disclose to the representative named above confidential

Information *(only the information which is necessary to answer the complaint)* about

me which I have provided to the practice.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /