TIMARU MEDICAL CENTRE

PATIENT COMPLAINT FORM **DATE: / /**

PART A: Patient's details	
Name:	
Address:	
Contact numbers: (Day)	(evening)
If you are complaining on someone's behalf	
Your name:	
Your relationship to the patient:	
Is the patient aware that you are complaining on their behalf? YES NO	
If someone is representing you (e.g. solicitor or advocate)	
Representative's name:	
Organisation:	
Postal address:	
Contact number(s):	

PART B: Event(s) leading to complaint		
Please describe the event you want us to know about, including the date(s) and other details that you can remember.		
What happened?		
Where did it happen?		
	Date:	**Time:**

Did anyone witness what happened?	
What was your complaints about? (e.g. a person, process, service)	
Is there anything else you would like to tell us about the event?	
What would you like to see happen as a result of this complaint?	

PART C: Further Information
Have you tried to resolve your complaint in any other way (e.g. by obtaining a second medical opinion)? If so, please give details.
Signature of patient or representative Date: / / 20 ____
Received by (practice staff) Date: / / 20 ____

Internal use only

PART D: Investigation & Outcome
Signature of complaints officer: Date: / / 20 ____
Letter sent to patient