Chew Lane
Chew Stoke
Bristol
BS40 8UE
Tel: 01275 332420

COMPLAINT FORM

Patient Name: ……..

Date of Birth: ……

Address: ……..
……
……
……
……

Contact telephone number ……

Email address ……..

What is your preferred way for us to contact you ……

How often would you like us to update you? Every one / two weeks

Complaint details: (Include dates, times, and names of practice personnel, if known)
Bullet points
……
……
……
……
……
……
……
……
……
……
……
……
……
What outcome are you looking for?
……
……
……
……
……
……

SIGNED……Print name…… Date……

(Continue overleaf if necessary)

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____
TELEPHONE NUMBER: _____
ADDRESS: _____
_____
_____
_____

ENQUIRER / COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____
_____
_____
_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.

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

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until…….. (insert date)

Signed: ……. (Patient only)

Date: ……..