

CONFIDENTIAL

St Paul's & Ashfield Medical Centres
Complaints Form

<u>Complainant's Details</u>		<u>Patient's Details (where different)</u>	
Surname		Surname	
First Name		First Name	
Date of Birth		Date of Birth	
Address		Address	
Post Code		Post Code	
Telephone		Telephone	
Relationship to patient			

Consent

I hereby give my consent and authority for St Paul's/Ashfield Medical Centre representatives to investigate the circumstances of this complaint and to give information about my medical conditions and treatment as appropriate in response to this complaint to _____ (complainant)

Signed: _____ (patient). Date: _____

Date/Time of Incident or Event leading to Complaint			
GP(s) involved		Nurse(s) involved	
Staff involved			
Details of what happened (continue on a separate sheet if necessary)			

Date complaint form completed: _____

Please forward the completed form to Mrs A P Bagot-Moore, Practice Business Manager