Full Patient/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complainant name:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Post code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tel number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a comment / suggestion / complaint *(please delete as appropriate)*

Are you complaining on behalf of someone else Yes/No *(please highlight/delete as appropriate)*

*(If you are complaining on behalf of someone else, please complete the third party consent form at the back of this form)*

Comments/Suggestions/Complaint details:

*(Include dates, times, and names of practice personnel, if known)*

Please state specific areas you wish to be investigated and include additional information which may be helpful.

What are your expectations from Lister House following your complaint?

What would you like Lister House to do to improve things in the future?

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*(please continue on the back of this form if required…)*

SIGNED: ……………………………………………………………. DATED: …………………………….

PRINT NAME: …………………………………………………………….

THIRD PARTY CONSENT FORM

|  |
| --- |
| **If you are complaining on behalf of a patient or your complaint or enquiry involves the medical care of a patient, you must obtain their signed consent or if they are unable to sign due to disability/incapacity etc. or the concern relates to someone who has died, the signed consent of their next of kin will be required.** |
| **Full name of the Patient:**  | **Date of Birth:**  |
| **Please state your relationship to the patient (e.g. Mother, Son etc.):**  |
| **Patient’s Address:**  **Postcode:**   |
| **Patients Home Telephone number:**  | **Patient’s Mobile number:**  |
| **PATIENT CONSENT** |
| 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)***I, (Patient’s signature): ……………………………………………………………………….………….****Please print name: ……………………………………………………………………….………….** |
|  |
| **COMPLAINANT CONSENT** |
| **I, (Complainant signature):****Please print name:** | **……………………………………………………………………….………….****……………………………………………………………………….………….** |
|  | Dated: ………………………………………. |

WHAT HAPPENS NEXT

In the first instance, it may be necessary for the Complaints Manager to contact you to discuss timescales with you for a response and how you would like us to respond to your complaint.

**Please post your completed Complaint Form to:**

Janine Patton - Complaints Manager

Lister House Surgery, Fellow Lands Way, Chellaston, Derby, DE73 6SW