Complaints Form

Date:

Details of person making complaint:

Name: DOB:

Telephone:

Address:

Details of the patient involved if different from above:

Name: DOB:

Telephone:

Address:

Details of the event

Date of event:

Members of the team involved:

Complaint Details: (eg; Type of complaint – Clinical, Communication and attitude, premises, practice management, practice administration, safety, other). Please provide as much detail as you can.

The management team at Skye Medical Armadale will investigate your complaint promptly; are there any actions that the management team could reasonably take for you that you feel would resolve/improve your situation?

Name:

Signature: Date:

Thank you for taking the time to provide feedback to us. Please be rest assured that your complaint will be actioned as a matter of high importance and you will be contacted to both discuss the event and to be made aware of the actions that have been taken in response to your complaint. Our policy is that complaints are acknowledged by management within 2 working days. The course of further action will be dependent on the type of complaint.

Office Use:

Name of staff member acknowledging complaint:

Signature:

Date:

Name of manager receiving complaint:

Signature:

Date: