

Patient Complaint Form

Complainant's details

Name			
Date of birth			
Address			
Postcode		Tel number	
E-mail address			

Patient's details (if different from above)

Name			
Date of birth			
Please note: If you are making a complaint on behalf of a patient who is over 18 years old, they must give consent for you to deal with this complaint and for AHP to be able to communicate with you. Please find the consent form below.			
I,, consent to Adur Health Partnership releasing information to and discussing my care and medical record with the complainant.			
I hereby authorise.....to make this complaint on my behalf and I agree that Adur Health Partnership may disclose to this person (only insofar as is necessary to answer this complaint) confidential information about me.			
Signed by the patient:..... Date:.....			
Signed by the complainant:..... Date:.....			
Relationship to the patient:.....			
Address			
Postcode		Tel number	
E-mail address			

Practice location involved with this complaint (please tick)

Shoreham Health Centre	<input type="checkbox"/>	Manor Practice	<input type="checkbox"/>
Northbourne Medical Centre	<input type="checkbox"/>	Downsway Surgery	<input type="checkbox"/>

Please give the details of the complaint on page 2 of this form.

Patient Complaint Form – Continuation sheet

Patient's name	
Patient's date of birth	

Details of the complaint

Thank you for your time to put your complaint in writing.

Please email a completed form to wsxccg.ahp@nhs.net or hand it in to our Reception team.

For office use only:

<i>Complaint received on site date:</i>		<i>By:</i>	
<i>Complaint received by the Complaints Manager date:</i>		<i>By:</i>	