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| --- | --- |
| Name of patient: |  |
| Patient’s DOB: |  |
| Patient’s address: |  |
| Patient’s Contact Number/email address: |  |
| Complainant name (if different), and contact details:  |  |
| Concerns/Complaint/Feedback:(Please include what went wrong, the date it occurred, who was involved, and the outcome you are looking for): |  |
| Date: |  |
| Signed:  |  |

**RECEPTION:**

Issue patient/complainant a copy of the practice complaints leaflet and inform them that the Practice Manager will make contact on receipt of the form. Inform the patient/complainant they can have a F2F meeting if preferred, or the Practice Manager will telephone them – a completed form is not the only option to them.