ASPLEY MEDICAL CENTRE

COMPLAINTS FORM

COMPLAINT REF :		**DATE RECEIVED :**	

Complaint about :
Staff member/s (if applicable)

Details of complainant :	
Surname :	Forename(s)
Title :	Gender :
Date of Birth :	Ethnic Origin :
Disability : Yes / No* (*delete where applicable)	

Address :	
Postcode :	Telephone no :

Details of patient, if different from complainant :	
Surname :	Forename(s)
Title :	Gender :
Date of Birth :	Ethnic Origin :
Disability : Yes / No* (*delete where applicable)	

Address :

Postcode :	Telephone no :
Details of complaint (give brief, factual account of circumstances and complaint)	

Outcome expected by Complainant :

Preferred response :
Telephone call / meeting / letter or other :

Name :	**Title :**	

Authorisation :

I agree that all the details taken are an accurate record of my complaint.

I agree / disagree* [Delete as appropriate] to the details of this complaint being forwarded and personal information relating to this complaint being shared with other services involved in the complaint, in order to investigate and provide a response to this complaint. These services may include NHS CitiHealth Nottingham, NHS Nottingham City, Hospitals, Mental Health Services Social Care (formerly Social Services) and other relevant health or social care organisations.

Signed : **Date :**

To be completed only if you wish to authorise another person to complain on your behalf.

I authorise ………………………………………………….to pursue this complaint with

Aspley Medical Centre on my behalf.

Signed …………………………………………………………………….

Print name ……………………………………………………………….

PLEASE MARK COMPLETED FORMS FOR THE ATTENTION OF THE PRACTICE MANAGER AND RETURN TO THE RECEPTION DESK OR ALTERNATIVELY POST TO ASPLEY MEDICAL CENTRE, 509 ASPLEY LANE, ASPLEY, NOTTINGHAM, NG8 5RU OR EMAIL to aspleymedicalcentre@nhs.net