Patient Complaint Form

Section 1 My details are:

Mr/Mrs/Ms (other) _____ First Name _____ Last Name _____

Address _____

_____State _____ Postcode _____

Telephone: _____ Mobile: _____

Date of Birth: _____E-mail address _____

The best way to contact me is_____ Day: _____ Time: _____

Section 2 I want to complain about:

Provider /Staff Members Name_____

Date of Surgery: _____

Did you speak to anyone else at ADS regarding this matter before now? Yes No *(please circle)*

If yes, Who: _____ Date: _____

Section 3 In your own words please tell us why you are not happy with the care or service you received:

Use the space below to provide a short summary of your complaint. It is useful to include what happened, when it happened, who was involved and attach any relevant documents you have to the back of this form.

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(Please continue on a separate sheet if necessary)

Section 4 As a result of your complaint, what would you like to see happen?

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I understand that staff investigating this complaint may need to see and review my health records, but that all information will be kept confidential. I further understand that this complaint will in no way affect any care provided.

Signature: _____ **Date:** _____

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 5 business days.

Section 5 Please return this form to:

POST: Albury Day Surgery
ATT: **Manager**
4 Baker Court
West Albury NSW

Email: shaley@alburydaysurgery.com.au