

Complaint form

We are sorry that you have had an experience that fell short of your expectations. Please complete this form and return it to us so that we may investigate your complaint.

Section 1 - Details of the patient involved	
Title (please tick one):	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> Other:
Surname/Family name:	
Forename(s):	
Date of Birth (D/M/Y):	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
Telephone number:	
Email Address:	
Current Address:	
Postcode:	

Section 2 - Details of the complainant (if not the patient)	
Title (please tick one):	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> Other:
Surname/Family name:	
Forename(s):	
Telephone number:	
Email Address:	
Relationship to patient:	

Patient name:	
Patient date of birth:	

Section 3 - Details of the complaint

Please tell us what happened, including dates and the names of any persons involved.

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Section 4 - Complainant's signature

Complainant's signature:	
Date of signing:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / 20 <input type="text"/> <input type="text"/>

Section 5 - Patient signature (where the patient is not the complainant)

If someone is complaining on your behalf, please confirm:

- I authorise the complaint set out overleaf to be made on my behalf
- I agree the practice may disclose to confidential information about me to the complainant

Patient's signature:	
Date of signing:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / 20 <input type="text"/> <input type="text"/>

Please return this form to the practice::
Post: University Health Service, Building 48, University of Southampton, Highfield, Southampton SO17 1BJ
Email: surgery@unidocs.co.uk
Hand: Please hand in to reception