PATIENT COMPLAINT FORM

If you have a complaint or concern about the service you have received from the doctors or any of the personnel working in this practice, please let us know. We operate a practice complaint procedure as part of an NHS complaints system, which meets national criteria.

HOW TO COMPLAIN

We hope that we can sort most problems out easily and quickly, often at the time they arise and with the person concerned. If you wish to make a formal complaint, please do so AS SOON AS POSSIBLE - ideally within a matter of a few days. This will enable us to establish what happened more easily. Please address your complaint for the attention of the Practice Manager, Stockbridge Surgery, New Street, Stockbridge, SO20 6HG.

COMPLAINING ON BEHALF OF SOMEONE ELSE

We keep strictly to the rules of medical confidentiality (a separate leaflet giving more detail on confidentiality is available on request). If you are not the patient, but are complaining on their behalf, you must have their permission to do so. An authority signed by the person concerned will be needed, unless they are incapable (because of illness or infirmity) of providing this. A Third Party Consent Form is provided below.

COMPLAINT FORM

Patient Full Name:……………………………………………………………………………………….

Address:………………………………………………………………………………………………….

……………………………………………………Date of birth:……………………………………….

Complaint details: (Include dates, times, and names of practice personnel, if known)

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SIGNED………………………………….Print name…………………………(Continue overleaf if necessary)

SEAP ADVOCACY SERVICE- Free service for patients requiring assistance to complain. Please telephone 01962 440262 for Health Complaints Advocacy in Hampshire

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: ………………………………………………………………………………………...

Tel No:………………………………………… Date of birth:………………………………………………

ADDRESS:……………………………………………………………………………………………………

……………………………………………………………….Post code:……………………………………..

ENQUIRER / COMPLAINANT NAME: ……………………………………………………………………

Tel No: ………………………………………… Date of birth:………………………………………………

ADDRESS:……………………………………………………………………………………………………

………………………………………………………………Post code:……………………………………..

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT, OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT, THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT’S SIGNED CONSENT BELOW.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with, the person named above in relation to this complaint, and I wish this person to complain on my behalf.

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until…………………….. (insert date)

Signed: …………………………………………….. (Patient only) Date:…………………………………..

Print name:…………………………………………

TAKING IT FURTHER

If you remain dissatisfied with the outcome you may refer the matter to:

The Parliamentary and Health Service Ombudsman

Millbank Tower

Millbank

London

SW1P 4QP

Tel 0345 0154033

[www.ombudsman.org.uk](http://www.ombudsman.org.uk)