The information MUST be completed to investigate your complaint.

# Complainant information

|  |  |  |
| --- | --- | --- |
| Name | Address | Contact Details |
|  |  |  |

# what is reason for your complaint? Tick appropriate

|  |  |  |  |
| --- | --- | --- | --- |
| * Quality of Care * Misdiagnosis * Customer Service * Work Cover * Billing | * Abuse * Sexual contact * Misfiled prescription * Inappropriate prescribing * Excessive test/treatment | * Patient abandonment/neglect * Impaired provider * Failure to release patient records * False advertising | * Other, please explain…. |

# Details of the complaint

|  |
| --- |
| Provide a complete description of the complaint. Include facts, details, dates, locations, who, whom, when & where |
|  |
|  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your feedback. It is our policy to respond to your complaint/feedback within 7 business days.

# Complainant information

|  |  |  |
| --- | --- | --- |
| DATE RECEIVED | RECEIVED BY | REFERED TO |
|  |  |  |

# ACTION TAKEN BY THE PRACTICE

|  |
| --- |
|  |

# Priority

|  |
| --- |
| * High * Medium * Low |

# Status

|  |  |  |  |
| --- | --- | --- | --- |
| * Closed | | * Ongoing | * Further Action Required |
| Notes/Actions |  | | |
| Has this issue been discussed with Principles/Management? If so who and when. | | | |
|  | | | |
| Has the resolution been discussed with the complainant? If so date and time. | | | |
|  | | | |

Signature/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_