PELHAM MEDICAL PRACTICE

May 2022

PATIENT COMPLAINT FORM

Patient's Full Name: Date of Birth:

Address:

Telephone:

Detail the complaint below, including dates, times, and names of practice personnel, if known. Continue on a separate page where necessary.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Print name _____

Signed _____

Date _____

If you are not the patient named above please complete the attached authority form below and request that the patient signs.

Please return completed forms to the Practice Manager 17, Pelham Road, Gravesend, Kent, DA11 0HN or if easier email to kmccg.pelhammp@nhs.net

PELHAM MEDICAL PRACTICE

May 2022

PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM

PATIENT'S NAME: _____
DATE OF BIRTH: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

THIRD PARTY / COMPLAINANT NAME:_____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

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 Pelham Medical Practice releasing information to, and discussing my care and medical records with the person named above.

Please tick one of the following boxes, as appropriate to, indicate how long you would like this authority to last and provide dates where requested:

- ☐ For an indefinite period
- ☐ For a limited period this authority is valid until …… (insert date)
- ☐ For this complaint / issue only

Signed …… (Patient)

Date……

Please return completed forms to the Practice Manager 17, Pelham Road, Gravesend, Kent, DA11 0HN or if easier email to kmccg.pelhammp@nhs.net