

<b>RED ROOFS SURGERY COMPLAINTS/SUGGESTION FORM</b>
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<b>Contact person's details:</b>	
<b>Name:</b>	<b>DOB:</b>
<b>Address:</b>	
<b>Telephone number:</b>	

<b>Patient (if not contact person):</b>	
<b>Name:</b>	<b>DOB:</b>
<b>Address:</b>	
<b>Telephone number:</b>	

<b>Summary of events/suggestions:</b>
<i>Please include details of the occurrence, including date, time and staff involved, and of any suggestions that you would like to make. Continue overleaf if required.</i>

<b>Complaints only:</b>	
<b>(Where the complainant is not the patient)</b>	
<b>Patient's authority:</b>	
I, ....., hereby authorise the above complaint to be made on my behalf and I agree that members of the Practice staff may disclose (in so far as is necessary to do so to answer the complaint) confidential information about me which I have provided to them.	
<b>Patient's signature:</b>	<b>Date:</b>