GOSFORD HILL MEDICAL CENTRE
167 Oxford Road
Kidlington
Oxford, OX5 2NS
Tel no: 01865 374242

PATIENT COMPLAINT FORM

The doctors, nurses & staff at this practice always endeavour to provide a good and caring service to our patients. If you feel that you wish to complain about an aspect of your care, please complete this form.

(Complaints about the Community Nursing Team or the Health Visiting Team should be directed to Oxford Health)

Your Full Name: .....
(if complaining on behalf of a patient)

Patient Full Name: .....

Date of Birth: .....

Address: .....
.....

Telephone No: .....

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

SIGNED…….Print name……

Patient ethnicity: ……
(we are required by the NHS to ask for this information)

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PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____
TELEPHONE NUMBER: _____
ADDRESS: _____
_____

ENQUIRER / 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 THAT 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 only, 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: ……..

*For office use only

Telephone/ in person/ letter/ email
Staff contact name:
Acknowledgement sent: