**Ribblesdale Medical Practice**

**Complaint Form – Third Party**

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I confirm I would like Ribblesdale Medical Practice to investigate my complaint and provide the necessary permission: -

* Share the complaint with the persons involved.
* Discuss the complaint at the practice meeting for the purpose of shared awareness raising, learning outcomes and quality improvement.
* Access the medical records for the purpose of reviewing the complaint.
* Receive a response in writing to your home address □ or Email □ (please tick your preferred method)

|  |  |
| --- | --- |
| **Patients full name (in capitals):** |  |
| **Patients Address:** |  |
| **Patients Date of Birth:** |  |

Does the patient have capacity to provide consent to making a compliant?

**Yes □ No □**

**If you answered yes to the above question, please ask the patient to sign the declaration below: -**

**I (name of patient) ……………………. confirm I would like (name of**

**complainant) …………………………………………. to act on my behalf to raise a complaint about my care and treatment at Ribblesdale Medical Practice.**

**Signed …………………………………… Date ………………………………………...**

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| **Your full name (in capitals):** | |  | |
| **Your address:** | |  | |
| **Your Relationship to the Child:** | |  | |
| **Your home telephone number:** | |  | |
| **Your mobile telephone number:** | |  | |
| **Your email address:** | |  | |
| **Signature:** | |  | |
| **Date:** | |  | |

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| Details of Complaint |