Barnsley Healthcare Federation

Better Health, Better Care, for a Better Barnsley

PATIENT FEEDBACK FORM
(To record complaints, comments or compliments)

Patient Full Name:

Date of Birth:

Address:

Details: (Include dates, times, and names of practice personnel, if known)

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……

(Continue overleaf if necessary)

PLEASE COMPLETE THE SECTION BELOW FOR COMPLAINTS ONLY:

How would you like this to be resolved? Please indicate:

- ☐ Telephone discussion
- ☐ Letter
- ☐ Face to face meeting
- ☐ Meeting with advocacy support

I fully consent to the Federation releasing my information as necessary in order to deal with my complaint.

Signed…….Print name…….
Date……..

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PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM

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 THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.

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I fully consent to the Federation releasing information to, and discussing my care and medical records with the person named above.

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)

Date ……..