THE SPRINGS HEALTH CENTRE

Recreation Close, Clowne, Chesterfield, S43 4PL

Telephone: 01246 819444 Fax 01246 819010

www.thespringshealthcentre.co.uk

**PATIENT COMPLAINT FORM**

|  |  |
| --- | --- |
| Date: |  |
| Patient’s Name: |  |
| Patient’s Date of Birth: |  |
| If not the patient, name, address and telephone number of person completing this form: |  |
| If not the patient, has consent been gained from the patient giving permission for us to discuss their medical records with you? A Third Party Consent Form will need to be completed.  |  |

Complaint details: (include dates, times and names of Practice personnel, if known)

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(Please continue on a separate sheet if necessary)

Signed ………………………………………….. Print Name …………………………….

Your complaint will be investigated by The Management Team and a response will be sent to you within 10 working days.

**Please return to Janina Gawel, Practice Manager, The Springs Health Centre, Clowne, Derbyshire, S43 4PL**