

Feedback and Complaints Form

Your feedback is important to us.

Rural Medical Clinic welcomes feedback from patients and uses complaints and concerns to help improve the quality and safety of our services
Please complete this form if you would like to raise a concern, make a complaint or provide feedback about the care or service you have received.

Your Details

Full Name: _____

Date of Birth: ____/____/____

Telephone: _____

Email: _____

Preferred method of contact:

☐ Telephone ☐ Email

☐ Written response ☐ Other: _____

Would you like to make this complaint anonymously?

☐ Yes ☐ No

Please note that if you choose to remain anonymous, the practice may be limited in its ability to investigate your concerns or provide you with a response.

Details of Your Concern or Complaint

Date the issue occurred (if known): ____/____/____

Approximate time: ____:____ am pm

Where did the issue occur: _____

Who was involved, if known: _____

Please describe your concern or complaint, including what happened:

Have you raised this concern previously?

☐ No ☐ Yes – please provide details: _____

What outcome are you seeking?

Please tell us what you would like the practice to know or what outcome you are seeking.

Additional Information

Please provide any other information that may assist us in understanding or investigating your concern. You may attach additional documents if required.

Attachments included:

☐ Yes ☐ No

Outcome/resolution:**Response provided to patient:**

- ☐ Yes
- ☐ No
- ☐ Not applicable/anonymous complaint

Date response provided: ____/____/____

Method of response:

- ☐ Telephone ☐ Email
- ☐ Written response ☐ Face to face
- ☐ Other: _____

Further action required:

- ☐ No
- ☐ Yes – details: _____

Complaint closed date: ____/____/____

Does this complaint identify an opportunity for improvement?

- ☐ No
- ☐ Yes

Quality improvement/action identified:

Entered into complaints/incident register:

☐ Yes

☐ No

☐ Not applicable

Completed by: _____

Date: ____/____/____