THE ELMS MEDICAL PRACTICE
PATIENT COMMENTS AND COMPLAINTS FORM

PERSONAL DETAILS

Name: ----------

DOB: ----------

Address: ----------

Contact Tel No: ----------

DETAILS OF COMMENT/COMPLAINT
(Please provide as much information as possible)

Date of Incident (if applicable) ----------

Patient Signature ----------

Please continue on the reverse of this sheet if necessary

Please return the completed sheet to a member of the Practice for the attention of the **Practice General Manager**

February 2020