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 of paper if necessary.)

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

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

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