



OTOROHANGA MEDICAL  
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# PATIENT COMPLAINT FORM

## PART A: Patient's details

Name:

Address:

Contact numbers: (day)

(evening)

### If you are complaining on someone's behalf

Your name:

Your relationship to the patient:

Is the patient aware that you are complaining on their behalf? YES NO

### If someone is representing you (e.g. solicitor or advocate)

Representative's name:

Organisation:

Postal address:

Contact number(s):

## PART B: Event leading to complaint

Please describe the event you want us to know about, including the date(s) and other details that you can remember.

What happened?

Where did it happen?

Date:

Time:

Did anyone witness what happened?

What is your complaint about (e.g. a person, process, service)?	
Is there anything else you'd like to tell us about the event?	
What would you like to see happen as a result of this complaint?	

**PART C: Further information**

Have you tried to resolve your complaint in any other way (e.g. by obtaining a second medical opinion)? If so, please give details.

Signature of patient or their representative .....