CLANNAD Medical Centre

GP Practice
1st Floor Kilbarrack Shopping Centre
Kilbarrack Dublin
Tel: (01) 848 0855
Email: clannadappointments@gmail.com

COMPLAINT FORM

A: Your details

Surname _____

Forename (s) _____

Title: Mr/Mrs/Miss/Ms/if other please state: _____

Address _____

_____

_____

Medical Card number (if applicable) _____

Your email address _____

Daytime telephone number _____

Mobile number _____

Please state by which of the above methods you would like us to contact you

_____

Your requirements
If our usual way of dealing with complaints is difficult for you, please tell us so that we can discuss how we might help you.

The person who experienced the problem should normally fill in this form. If you are filling this in on behalf of someone else, please fill in section B. Please note that before taking forward the complaint we will need to satisfy ourselves that you have the authority to act on behalf of the person concerned.

B: Making a complain on behalf of someone else: their details

Their name in full _____

_____

Their address _____

_____

_____

What is your relationship to them? _____

Why are you making a complaint on their behalf?

C: About your complaint (Please continue your answers to the following questions on a separate sheet if necessary)

What do you think we did wrong, or failed to do?

Describe how you personally or the person you are representing suffered or has been affected

What do you think should be done to put things right?

Have you already put your concern to the frontline staff responsible for delivering the services? If so, please give brief details of how and when you did so.

If you have any documents to support your concern/complaint, please attach them with this form.

Signature:

Date:

When you have completed this form, please send it to:

The Practice Manager
Clannad Medical Centre
Swans Nest Road
Kilbarrack
Dublin 5