



Complaint Form

If you have any queries about filling in this form
please contact us.
Tel 01463 712233

Please use BLOCK CAPITALS and remember to sign the form at the end

1 Complainant Details

Name

Address

Post code

Home telephone no.

Email

If you are complaining on behalf of someone else, please complete section 2 as well. If not, please go to section 3.

2 Complaining on behalf of someone else

ONLY complete this section if you are making the complaint on behalf of someone else

Name

Address

Post code

Home telephone no.

Email

What is your relationship to the person on whose behalf you are complaining?

Please tell us why that person is not making the complaint him/herself.

You should read the consent form on the back page and if applicable ensure that it is signed by the person who would like to you act on their behalf.

Complaining on behalf of someone else

You can complain for someone else if you:

- have their agreement to complain – the patient would also need to agree that staff could look at their health records if necessary
- are a child's parent, guardian or main carer and your child is not mature enough to understand how to make a complaint
- have a welfare power of attorney or a welfare guardianship order for someone who cannot make decisions for themselves, and the order specifies that you have the power to make a complaint about health care
- are a relative of, or had a relationship with, a patient who has died and you were concerned about how they were treated before they died, or
- are acting as an advocate for the patient

3 What are you complaining about?

Please describe what has gone wrong

4 How have you suffered as a result?

5 What would you like to happen?

Please tell us what would help to put things right

Continue on a separate sheet if necessary

6 Consent to access medical record

If your complaint is about a clinical matter, we will need information from your health record to be able to answer your complaint. This information is shared on a need-to-know basis. If you would prefer us not to access your health record, you can withhold your consent. This may affect our ability to fully investigate your complaint.

| Consent to Access my medical record | Tick ONE box only |
|---|--------------------------|
| I give my consent to Cairn Medical Practice complaints team to access my medical record in order to answer my complaint | |
| I do not give consent to Cairn Medical Practice complaints team to access my medical record in order to answer my complaint. I understand that this may affect the practice's ability to fully investigate my complaint. | |

| | |
|---------------|-------------|
| Signed | Date |
|---------------|-------------|

7 Complainant Representative Consent

Please fill this in if you want someone else to make a complaint for you:

| | |
|--|-------------|
| Name | |
| Address | |
| I authorise (name of person) _____ | |
| Of (their address and contact details) _____ | |
| _____ | |
| to make a complaint on my behalf to Cairn Medical Practice. I understand that this may result in Cairn Medical Practice disclosing to my representative personal information relating to myself and the complaint I am making, including health information from my medical record where this is necessary to answer the complaint. | |
| Signed | Date |

Please return this form to

Feedback and Complaints Officer
Cairn Medical Practice
15 Culduthel Road
Inverness IV2 4AG
OR

Email: nhsh.gp56006-admin@nhs.scot for the attention of the Feedback and Complaints Officer