

TO Practice Manager, Riverside Medical Practice, Inverness

SUGGESTION/COMPLAINT FORM (delete as appropriate)

Name: DoB:

Address:

Patient details (where different from above)

Name:

Address:

Date of Birth: Usual Doctor:

Details of suggestion or complaint: Please include date(s) of events and persons involved. Continue overleaf where necessary.

Signature: **Date:**

Where the complainant is not the patient

I authorise the complaint set out overleaf to be made on my behalf by and I agree that the practice may disclose to (only in so far as is necessary to answer the suggestion/complaint) confidential information about me, which I provided to them.

Patient signature **Date**

Name and address

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