Point of Contact Complaint Escalation Form

Your Service Your Say

Complainant Details:

Name _____

Address _____

_____

Tel. no: _____

Email Address: _____

Is the complainant a: *Patient* ☐ *Relative of a Patient* ☐ *Member of the Public* ☐

Brief overview of Complaint

_____

_____

_____

_____

Date and time of complaint: _ _ / _ _ / _ _ _ _ _____ (please use 24 hour clock)

Who was involved? *(Please list all persons involved including patient or staff member details)*

_____

_____

_____

What outcome would the complainant wish to result from their complaint ?

_____

_____

To be completed by Complainant: Name: _____

Signature _____ **Date** _____ **Consent Given: (Yes/No)** _____

Line Manager:

Briefly describe why complaint was not resolved at point of contact:

_____

_____

_____

_____

Manager Name: _____

Service Location: _____

Contact Tel: _____

Email: _____

Signature: _____

Form to be completed in full and sent to the Complaints Officer