



## CONCERNS FORM – Llanishen Court Surgery

### Section A: YOUR DETAILS

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Are you the Patient?      YES      NO

### Section B: A CONCERN ON BEHALF OF SOMEONE ELSE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### Section C: DETAILS ABOUT THE CONCERN

If you are raising this concern on behalf of someone else, what is your relationship to the patient?

\_\_\_\_\_

Date event/incident occurred: \_\_\_\_\_

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

\_\_\_\_\_

Summary of your concerns/key issues:

Specify the questions you would like answered:

Details of what you would like to happen as a result of your complaint:

**Section D: Please choose how you would like us to contact you**  
**(Options: EMAIL; TELEPHONE; LETTER**

Email: \_\_\_\_\_

Contact: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**To be completed when the person raising the concern is not the patient:  
I hereby authorise**

**Name of Person Raising the Concern:**

**Address:**

**to act on my behalf and to receive any and all information that may be relevant to the concern.**

**I hereby agree that the health records and any personal information can be used in the investigation of concern. I understand that access to records and personal information will be limited only to those who need to see them in order to investigate the issues raised and, only those sections of the health records relevant to the investigation will be used.**

**Signature of Patient** \_\_\_\_\_ **Date:** \_\_\_\_\_