Elermore Vale Medical Centre
Shop 10, 137 Croudace Road
Elermore Vale NSW 2287
Phone: 02 4038 9181
Fax: 02 4038 9182
reception@evmc.au
www.evmc.au

PATIENT COMPLAINT & FEEDBACK FORM

Thank you for taking the time to provide your feedback. Elermore Vale Medical Centre is committed to providing safe, high-quality healthcare. Your comments, compliments and complaints help us improve our services.

I wish to lodge a complaint with Elermore Vale Medical Centre.

Section 1 My details are:

Title: Mr / Mrs / Ms / Miss / Dr / Other _____

First Name: _____ **Last Name:** _____

Address: _____

_____ **Postcode:** _____

Home Phone: _____

Mobile: _____

Email: _____

Date of Birth: ____ / ____ / _____

Preferred method of contact: ☐ Home Phone ☐ Mobile ☐ Email ☐ Letter

I am lodging this complaint on behalf of: ☐ Myself (go to page 2) ☐ Another person (complete Section 2)

Section 2 Details of the patient who received the service are:

Title: Mr / Mrs / Ms / Miss / Dr / Other _____

First Name: _____ **Last Name:** _____

Address: _____

_____ **Postcode:** _____

Home Phone: _____

Mobile: _____

Email: _____

Date of Birth: ____ / ____ / _____

Relationship to the patient: _____

Is the patient aware you are making this complaint? ☐ Yes ☐ No

Section 3 Details of the complaint:

Date the incident occurred: _____

Doctor, Nurse or Admin Member involved:_____

Please describe your concerns. Include as much detail as possible, including what happened, where it occurred and who was involved.

(Attach additional pages if required.)

What outcome are you seeking?

Please tell us how you would like this matter resolved.

Supporting Information

Have you previously discussed this matter with anyone at the practice? ☐ Yes ☐ No

If yes, who? _____

When? _____

Have you attached any supporting documents? ☐ Yes ☐ No

If yes, please list them:

Privacy & Consent

I understand that Elermore Vale Medical Centre will investigate my complaint and may need to discuss the matter with staff involved in my care. I consent to the use of my personal information for the purpose of investigating and responding to this complaint.

I understand that my healthcare will not be affected because I have raised a complaint.

Declaration

I declare that the information provided in this form is true and correct to the best of my knowledge.

Name: _____

Signature: _____

Date: ____ / ____ / _____

Please send the information to:

Practice Manager
Alison Thomas
practicemanager@evmc.au
Shop 10-13, 137 Croudace Rd
Elermore Vale NSW 2287
Ph: 02 4038 9181

If you are not satisfied with the outcome of your complaint, you may contact the NSW Health Care Complaints Commission (HCCC) for independent advice or to lodge a complaint.

NSW Healthcare Complaints Commission
Level 12, 323 Castlereagh Street (corner of Hay St)
SYDNEY NSW 2000
Phone: 1800 043 159

Office Use Only

Date Received: _____

Received By: _____

Complaint Reference Number: _____

Action Taken:

Outcome:

Date Closed: _____

Reviewed By: _____