COMPLAINTS FORM

The information MUST be completed to investigate your complaint.

At Ralifah Medical Centre, we highly value your feedback and are dedicated to listening with care and empathy. Your insights are invaluable in helping us enhance and improve our services. We appreciate you taking the time to share your experience.

COMPLAINANT INFORMATION		
Name	**Address**	**Contact Details**

WHAT IS THE REASON FOR YOUR COMPLAINT?			TICK APPROPRIATE
– Quality of Care – Misdiagnosis – Customer Service – Work Cover – Billing	– Abuse – Sexual contact – Misfiled prescription – Inappropriate prescribing – Excessive test/treatment	– Patient abandonment/neglect – Impaired provider – Failure to release patient records – False advertising	– Other, please explain….

DETAILS OF THE COMPLAINT
Provide a complete description of the complaint. Include facts, details, dates, locations, who, whom, when & where.

Signature: _____ Date: _____

(Required to file a complaint)

Thank you for your feedback. It is our policy to respond to your complaint/feedback within 7 business days.

COMPLAINTS FORM

COMPLAINANT INFORMATION		
DATE RECEIVED	**RECEIVED BY**	**REFERED TO**

ACTION TAKEN BY THE PRACTICE

PRIORITY
– High – Medium – Low

STATUS		
– Closed	– Ongoing	– Further Action Required

NOTES/ACTIONS	

Has this issue been discussed with Principles/Management? If so, who and when.

Has the resolution been discussed with the complainant? If so, date and time.

Signature/Name: _____ Date: _____

(Required to file a complaint)