North Coast Medical Centre BYRON INTEGRATIVE HEALTH

Feedback Form

The following details are recorded for complaints and placed in the complaints file.

Staff member taking feedback	
Name (printed):	**Signature:**

How was the grievance made? (e.g. phone, in person, letter)		
Date:	**Time:**	**Location in practice:**

Details of issue	
Complainant name:	**File ID:**
Address:	**Phone:**

Description of grievance (from complainant's point of view)		
☐ Privacy	☐ Other Health Issue	Date:
Description:		

What action was taken?		
Description:		
Incident form completed?	☐ Yes	☐ No

Practice Manager notification:	Date:	Time:
Date complaint acknowledgement letter sent:	Date: ☐ Yes	☐ No
Situation Resolution		
Situation resolved?	Date: ☐ Yes	☐ No
If no, referred further action to:	☐ National Privacy Commissioner	☐ Health Services Commissioner
Referred for discussion at Practice Mtg?	☐ Yes	☐ No