

**Moss Valley Medical Practice**

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**Gosforth Valley Medical Practice**

Gorsey Brigg, Dronfield, Derbyshire, S18 8UE

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| **Making a Complaint on Behalf of Someone Else – Complaint Form** |

**Please use this form if you would like to make a formal complaint on behalf of someone else about the service they have received at this practice.**

Please note that this form is for formal complaints only. Should you wish to share a compliment or comment, please use the **Patient Compliments and Comments** form.

1. **Your Details**

(This should be the details of the person making the complaint)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** | |  | |
| **Address:** |  | | | | |
| **Postcode:** |  | **Email address:** | |  | |
| **Telephone number:** |  | **Relationship to patient:** | |  | |
| **What is your preferred method of communication?** | | Email | Phone | | Post |

1. **Patient Details**

(This should be the details of the person you are making the complaint on behalf of)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** | |  |
| **Address:** |  | | | |
| **Postcode:** |  | **Telephone Number:** | |  |
| **Main Surgery:** | Gosforth | | Moss Valley | |

1. **Information about the Complaint**

|  |  |  |
| --- | --- | --- |
| **On what date(s) or over what period of time did the issue happen?** | |  |
| **Who was involved?** |  | |
| **What happened?** (please continue on a separate sheet if necessary) |  | |
| **What happened?** (continued) |  | |
| **What would you like to see as an outcome of your complaint?** |  | |

I fully consent to The Valleys Medical Partnership releasing information to, and discussing my care and medical records with, the complainant in relation to the above complaint.

I hereby authorise the person named above to make this complaint on my behalf, and I agree that confidential information about me may be disclosed to them (only insofar as is necessary to answer the complaint).

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed** (Patient)**:** |  | **Dated:** |  |