# KAIKOURA HEALTHCARE PATIENT COMPLAINT form

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| **part a: Patient’s details** | |  | |
| Name: | | | |
| Address: | | | |
| Contact numbers: (day) | | (evening) | |
| **If you are complaining on someone’s behalf** | | | |
| Your name: | | | |
| Your relationship to the patient: | | | |
| Is the patient aware that you are complaining on their behalf? YES NO | | | |
| **If someone is representing you (e.g. solicitor or advocate)** | | | |
| Representative’s name: | | | |
| Organisation: | | | |
| Postal address: | | | |
| Contact number(s): | | | |
| **part b: Event leading to complaint** | | | |
| **Please describe the event you want us to know about, including the date(s) and other details that you can remember.** | | | |
| What happened? |  | | |
| Where did it happen? |  | | |
| Date: | | Time: |
| Did anyone witness what happened? |  | | |
| What is your complaint about (e.g. a person, process, service)? |  | | |
| Is there anything else you’d like to tell us about the event? |  | | |
| What would you like to see happen as a result of this complaint? |  | | |
| Do we have your permission to speak with the people necessary to resolve the complaint? |  | | |
| **part c: Further information** | | | |
| Have you tried to resolve your complaint in any other way (e.g. by obtaining a second medical opinion)? If so, please give details. | | | |
| What you disclose will remain confidential unless we request your permission to share the information with someone for the purposes of the investigation and resolution of your complaint. | | | |
| **Signature of patient or their representative** | | | |
| **Received by** | | | |
| **Date** | | | |