

Harbourside Health Centre/ St. David's Medical Centre

Appendix F – Template for recording concerns to be handled by the Practice Manager at the GP Practice.

This form should be completed when someone wishes to raise their concerns. A copy of the completed form should be sent to the Practice Manager either by e-mail to practice.manager.w98056@wales.nhs.uk or by post to

*Harbourside Health Centre
Beacon Centre for Health
Langdon Road
Swansea
SA1 8QY*

SECTION A: Details of person raising the concern (ie the patient or someone on their behalf)

Title – Mr/Mrs/Miss/Ms or state other:
Name in full: and date of birth:
Address and postcode:
E-mail address:
Daytime contact number and/or mobile number:

Please indicate the method you prefer to be contacted by:

[] Written: Post []
 Email []

Or

[] Verbal: Phone []

If you have any special requirements, for example English is not your first language or you have a sensory impairment, please tell us:

SECTION B: Details of the person who the concern is about if different to section A

Title – Mr/Mrs/Miss/Ms or state other:
Patient's name in full: and date of birth:
Patient's Address and postcode:
What is your relationship to this patient? i.e. friend/relative/next of kin/advocate/carer etc.

**SECTION C: Details about the concern
(please answer the following questions and
continue on a separate sheet(s) if necessary).**

1. Name of the GP Practice staff member/service you have concerns with.
2. Outline of concerns - What do you think they did wrong, or failed to do?

3.	Describe how you personally and or the patient have suffered or have been affected.
4.	What do you think should be done to put things right?
5.	Date concern occurred or when did you first become aware of the concern.
6.	If it is more than 12 months since you became aware of the concern, please give the reason why you have not raised this concern before now?
7.	Please state if you are attaching any documents to support your concern.
Yes/No	

SECTION D:

If the person raising the concern is the patient please read the statement and sign below – if you are not the patient, ignore this section and please ask the patient to complete section E.

I hereby agree that my health records and any personal information can be used in the investigation of my concern. I

understand that access to my records and personal information will be limited to what is relevant to the investigation of the concern and will only be disclosed to people who need to know it in order to investigate my concern.

Signature of patient:

Date:

SECTION E:

If person raising the concern is not the patient:

I hereby authorise

Name of person raising the concern:

Address (if different from above):

to act on my behalf and to receive any and all information that may be relevant to the concern.

I hereby agree that my health my health records and any personal information can be used in the investigation of my concern. I understand that access to my records and personal information will be limited to what is relevant to the investigation of the concern and will only be disclosed to people who need to know it in order to investigate my concern.

Signature of patient:

Date:

Please note that this document (if being e-mailed) will need to be scanned once completed and then sent, as we do not accept electronic signatures.

HARBOURSIDE HEALTH CENTRE
REVIEWED NOVEMBER 2020 by Liz Llewelyn
NEXT REVIEW DUE NOVEMBER 2021