Sir Charles Gairdner Hospital
COMPLAINTS FORM

Respond No: _____

This form is available in alternative formats upon request.
Telephone 08 9346 2867.

COMPLAINANT DETAILS	PATIENT / CLIENT DETAILS
NAME:	**NAME:**
ADDRESS:	**ADDRESS:**
POST CODE:	**POST CODE:**
PH(H) **PH(W/M)**	**PH (H)** **PH (W/M)**
RELATIONSHIP TO PATIENT/CLIENT:	**UMRN:** **DOB:**
GENDER: (Please circle) MALE FEMALE	GENDER: (Please circle) MALE FEMALE
OPTIONAL - Please describe your ethnicity?	DATE OF COMPLAINT:
LANGUAGE SPOKEN:	LANGUAGE SPOKEN:
INTERPRETER REQUIRED YES NO	INTERPRETER REQUIRED YES NO
INTERPRETER USED: YES NO	INTERPRETER USED: YES NO
OPTIONAL: Are you a Carer? YES NO Do you have a Disability you would like us to know about? YES NO	OPTIONAL: Are you a Carer? YES NO Do you have a Disability you would like us to know about? YES NO
DATE OF INCIDENT:	LOCATION OF INCIDENT:

SUMMARY OF COMPLAINT (What happened? Where did it happen? Who was involved?)

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF LODGING THIS COMPLAINT?

HOW WOULD YOU LIKE TO BE GIVEN YOUR COMPLAINT RESPONSE:
☐ IN WRITING ☐ VERBALLY ☐ NO RESPONSE REQUIRED

HOW WAS THE COMPLAINT MADE:

LETTER ☐ FEEDBACK FORM ☐ EMAIL ☐ TELEPHONE ☐ IN PERSON ☐ OTHER:

WHO TOOK THE COMPLAINT? (PRINT NAME)

CONTACT NUMBER: DATE

ADMISSION STATUS:

INPATIENT ☐	PUBLIC ☐	VOLUNTARY ☐	VISITOR ☐
OUTPATIENT ☐	PRIVATE ☐	INVOLUNTARY ☐	OTHER ☐

Note: Complaint documents are <u>not</u> to be stored on patient's medical record

OFFICE USE ONLY

AUTHORISATION: **REQUIRED?** **Yes** **No** **RECEIVED?** **Yes** **No**

HEAD SHEET CALLED: **Yes** **No** **DATE:**_____

Delivery area:_____

CATEGORIES OF COMPLAINT:		**SUB-CODE / AREA TO RESPOND.**
1. ACCESS		
2. COMMUNICATION		
3. DECISION MAKING		
4. QUALITY OF CLINICAL CARE		
5. COSTS		
6. RIGHTS, RESPECT & DIGNITY		
7. GRIEVANCES		
8. CORPORATE SERVICES		
9. PROFESSIONAL CONDUCT		
10. CARERS		

RISK SCORE (Please Circle):

Low Risk Medium Risk High Risk Extreme Risk

OFFICE USE ONLY CONSUMER OBJECTIVE		**OUTCOME/RESOLUTION FOR THE COMPLAINT**		**RECOMMENDATION/ACTION TAKEN**	
Receive an explanation		Concern registered		Quality improvement activity initiated including risk management initiated and system wide changes made.	
Explanation provided		Explanation provided		Policy and/or procedure written or modified.	
Obtain and receive an apology		Apology provided		Training/education of staff provided	
Obtain a refund/compensation		Costs refunded		Staff member/contractor counselled and offered performance support	
Access to services		Service Provided		Duties changed	
Change procedure effected		Change in practice/procedure/effected		Formal warning given	
Change in the policy		Change in the policy effected		Formal warning documented on personnel record	
The hospital/health service will accept and acknowledge its responsibility for the complaint.		Compensation received		Registration Board notified	
		The hospital/health service will accept and acknowledge responsibility for complaint		No further action required	

PLS OFFICE USE ONLY	**DATE**	**SIGNATURE**		**DATE**	**SIGNATURE**
ENTERED ON RESPOND			OUTCOME ENTERED		
ACKNOWLEDGEMENT			REPORTED TO ED SCGH/NMAHS		
DELAY - UPDATE SENT			REPORTED TO LEGAL		
FINAL RESPONSE			REPORTED TO PR		
S,Q & P INVOLVEMENT - Yes No N/A Co-Director/s advised - Yes No N/A			MISCONDUCT QUERY - REPORTED TO HR		

SYSTEMS IMPROVEMENT– Process/quality improvement initiated as a result of this complaint.

Note: Please attach any statements / additional information relevant to the investigation