332 OLD CLEVELAND ROAD
COORPAROO QLD 4151
PH 07•33974151 FAX 07•33974153
reception@coorparooclinic.com.au

COMPLAINTS FORM

Name (person lodging complaint):	Patient/Visitor/Staff
Address:	(Please circle)
Home Phone:	
Mobile Phone:	

Date of Complaint/Feedback:
Date Incident Occured:
Complaint/Feedback Reported to:
Description of Complaint/Feedback: ....

OFFICE USE ONLY

Action Taken:	
What can be done to prevent a re-occurence?	
Was the person responsible advised? [ ] YES [ ] NO Advised By:	Date:
Was the complainant advised of action taken? [ ] YES [ ] NO Advised By:	Date:
Has the Business Development Manager been notified? [ ] YES [ ] NO	
Is any further action required? [ ] YES [ ] NO If yes please detail	
Name:	Sign:
Position:	Date: