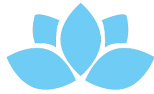


BRISBANE
DAY HOSPITAL

Patient Complaint Form

Patient name (please print): ______________________________ Date of birth: _______________

Address: ____

Phone: __________________________________ Mobile: __________________________________

This concern is regarding my bill: ☐ Yes ☐ No

This concern is regarding my patient care: ☐ Yes ☐ No

1. Did you discuss this concern with a member of your health care team: ☐ Yes ☐ No
2. Please write a brief statement

Who was involved: ____

When did the issue occur: ____

Where did the issue occur: ____

What happened?

____

____

____

____

____

(Use back of form in necessary and/or attach related documents)

As a result of making this complaint, is there any outcome you would like? ☐ Yes ☐ No

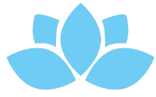
If yes, please provide details:

____

____

Witness's if applicable: ____

Brisbane Day Hospital
687 Logan Road, Greenslopes
Queensland 4120



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Thank you

Brisbane Day Hospital
687 Logan Road, Greenslopes
Queensland 4120