TE MARAE ORA
COOK ISLANDS Ministry of Health

Patient complaint form

Name of complainant: _____

Name of patient: _____

Address: _____

Phone: _____

Are you the patient? Yes No
If no, please state your relationship to the patient: _____

Where did the problem occur?

Rarotonga Hospital Tupapa Primary Health Care Main Office Tupapa Dental Puna/Clinic
Other (Please specify): _____

Nature of complaint: _____

_____

_____

_____

_____

_____

_____

Name(s) of staff involved: _____

_____

Were there any witnesses? If so, please list their name(s) and phone number: _____

_____

Did our staff attempt to correct the problem or resolve the situation when it occurred? Yes No

I understand that by signing this Patient complaint form, I request that Te Marae Ora Ministry of Health will investigate my complaint. I will provide any and all information and cooperate in helping Te Marae Ora Ministry of Health resolve my complaint. The information I have and will provide is true and accurate.

Signature of patient: _____ Date: _____

Signature of complainant (If different from patient): _____ Date: _____