



Case number:

Please fill in the following information and return to the Health and Disability Service Complaints Office (HaDSCO), PO Box B61, Perth, Western Australia, 6838 as soon as possible.

Details of the person who used the health service (the consumer)

Name:

Address:

Date of birth: / /

Details of the complainant (If complaining on someone else's behalf or under the Carer's Recognition Act)

Name:

Address:

Date of birth: / /

Provider of the health service

Name:

Date service provided: / /

Authorisation to access information and authorisation to refer

In order to deal with your complaint, HaDSCO may need to obtain information or records. A copy of the complaint may also be sent to the provider for a response. Please read and sign the following authorisation statement.

'I authorise the Director of the Health and Disability Services Complaints Office to access information relating to this complaint, and to send a copy of my complaint to the health service provider or other body.'

Consumer's signature: _____ Date / /

Complainant's signature: _____ Date / /