marathon health
Better healthcare, closer to home

Complaint/Incident Form

Please circle the type of complaint/incident	Non Clinical	Clinical	Incident
Complaint/Incident Report Form			
Date of complaint/ incident:	____ / ____ / ____	Time of complaint/ incident	__________ am/pm
Location: (Include address, where applicable)			
Name of person completing form:			
Position of person completing form:		Contact number:	

Employees, Volunteers or Directors involved in complaint/incident:	
Name:	Contact number:

Clients or community members involved in complaint/incident:	
Name:	Contact number:

Description of complaint/incident and background:

(Include all relevant circumstances and information leading up to the incident, whether the incident was witnessed, and any other relevant issues.)

____

____

____

____

____

____

Who was informed of the complaint/incident? (For example, CEO, manager, police, fire brigade, family members, and so on.)	

Actions taken to date: (Including date and time of contact, contact number, and other contact numbers of agencies or people who were informed, as well details of support provided.)
1.

Follow up actions planned:
1.

Complaint/Incident Report Form authorised by:	
____ (Signature of employee)	Date: ____ / ____ / ____
____ (Signature of manager)	Date: ____ / ____ / ____

Optional:

Please refer to document #105 and rate the SAC code for this complaint/incident

This should be the initial SAC rating

Please circle the relevant Consequence	Serious	Major	Moderate	Minor	Minimum

Please circle the relevant Likelihood	Frequent	Likely	Possible	Unlikely	Rare

Terms and conditions

Please tick the box and sign below to agree to the Terms and Conditions.

❑ I understand that by signing this form I am stating that the information I have supplied provides a true and correct representation of the events that have occurred and that have prompted this complaint. I understand that the information I supply will be used by the organisation:

To further improve its service delivery

In accordance with relevant legislation

Signature: ___________________________________ Date: _____________________

Lodgment

Marathon Health will accept complaints in the following ways:

In writing:

- By mailing to ***The Quality Manager,*** **PO BOX 175, BATHURST NSW 2795**
- Faxed to ***02 6332 2899 – ATTENTION: The Quality Manager***
- By email to admin@marathonhealth.com.au **– ATTENTION: The Quality Manager**

In person:

- By discussing with the clinician providing your service
- By telephoning the ***Quality Manager*** on ***02 6333 2800***
- By handing the completed form to one of our staff at any service location

Processing complaints

We shall acknowledge all complaints within ***five*** working days and try to resolve complaints within ***10*** days.

Once reviewed, you will receive a written explanation of the outcome, and information regarding changes that will be made to policies, procedures, or other internal processes where relevant.

We shall have due regard to your privacy.

You may remain anonymous when lodging your complaint.

Document Control Box

Policy Number:	**Area**:	
Date Effective: Last Review:	Review Date:	Review Number:
Approved By:	Written By:	Person responsible:
Forms and References:		

SIGNED: ________________________________

DATE RATIFIED: ________________________________