

Review / Feedback / Complaints Form

MM OP 3001

Date _____

Your Name (*optional) _____

Contact Details (*optional) _____

Concern/Feedback:

Have you raised your concern/feedback with an In Home Care (IHC) Staff Member? Yes No

Staff Member's Name _____ Date of Contact _____

What outcome were you hoping for or would like to see?

Would you like IHC to contact you regarding this concern/feedback? Yes No

Thank you for your feedback. IHC will let you know we have received your complaint within three working days. We will seek to resolve your complaint as a priority.

** Please note, if you would like Marymead to contact you regarding your feedback, you will need to identify your name and contact phone number and/or address.*

