



## Elective Wait List Advocate Committee Complaint Form (Print and write in spaces)

### 1) Details of person who received the health service (the consumer)

Preferred title: \_\_\_\_\_  
Last name: \_\_\_\_\_  
First name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Post code: \_\_\_\_\_  
Phone numbers:  
(home): \_\_\_\_\_  
(mobile): \_\_\_\_\_  
(work): \_\_\_\_\_  
email: \_\_\_\_\_  
Female/male: \_\_\_\_\_  
Preferred language: \_\_\_\_\_  
Date of birth: \_\_\_\_\_

### 2) Provider of the health service

Name of hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone number: \_\_\_\_\_  
Hospital Contact: \_\_\_\_\_

### 3) If you are complaining on someone else's behalf, please provide your details:

Preferred title: \_\_\_\_\_  
Last name: \_\_\_\_\_  
First name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Post code: \_\_\_\_\_  
Phone numbers:  
(home): \_\_\_\_\_

(mobile): \_\_\_\_\_  
(work): \_\_\_\_\_  
email: \_\_\_\_\_  
Female/male: \_\_\_\_\_  
Preferred language: \_\_\_\_\_  
Date of birth: \_\_\_\_\_

What is your relationship to the consumer?

Guardian (yes/no): \_\_\_\_\_  
Carer (yes/no): \_\_\_\_\_  
Relative (eg. parent): \_\_\_\_\_  
Other (state type): \_\_\_\_\_

**Note:** If you are not a relative, please sign the following declaration:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Has the consumer given permission for you to act as his or her representative in this matter?

Yes/no: \_\_\_\_\_

If the consumer is unable to authorise you, please explain why, and describe your interest in the matter:

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#### 4) Your Complaint

Please explain your complaint. What has the provider done that you wish to complain about? If possible, supply critical dates, times, locations and copies of relevant documents (if there is insufficient space please attach additional paper).

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Signature of consumer,  
or authorised representative: \_\_\_\_\_  
Date: \_\_\_\_\_

## 6) Checklist

Thank you for filling out this form. So that we will be able to begin work on your complaint as soon as possible, please read through the checklist below to ensure that you have given us the correct information. It is important that you do this as the Committee cannot begin work on a complaint until we have the appropriate information and authorisation.

### Have you:

- Provided the details of the person who received the service?
- Provided the details of the hospital/person that provided the service?
- Provided your own details, if you are lodging a complaint on someone's behalf?
- Provided details regarding your attempts (if any) to resolve your complaint with the provider?
- Provided enough copies of any relevant documents?
- Authorised the Committee to access information regarding your complaint?

### Contact details

Postal Address: (send Complaint form and any attachments to)

### Private and Confidential

The Executive Officer  
Elective Wait List Advocate Committee  
Department of Health  
PO Box 8172  
Perth Business Centre  
PERTH WA 6849

Telephone: (08) 9222 6451

Fax: (08) 9222 2032

Email: [ElectiveAdvocate@health.wa.gov.au](mailto:ElectiveAdvocate@health.wa.gov.au)