**Saint John of God Community Services clg**

***Community Mental Health Services***

**Lucena Clinic CAMHS / CLUAIN MHUIRE Adult Services**

I would like to make a:

Comment,

Compliment,

Complaint

Name:

Address:

Phone Number:

Email Address:

Name of Service:

Where did this happen?

When did this happen?

In you own words please let us know what happened?

I am over 18 years of age for the purposes of investigation of my complaint. I grant permission to SJOGCS to access my personal patient confidential information.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name**

If you are a child or young person filling out this form please provide the name & signature of your **parent / guardian**. I am under 18 years

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name of parent/guardian Signature of parent/guardian**