ROYAL ADELAIDE HOSPITAL

PATIENT COMPLAINT FORM

YOUR DETAILS

Your name (Mr/Mrs/Miss/Ms) ……...…....

Address …….. Post Code……...….

Date of Birth …… RAH UR Record No. …….....

Telephone …… Mobile …….…. Fax ……...

DETAILS OF COMPLAINT: (please attach additional pages if required)

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Please send completed form to: Consumer Adviser
Royal Adelaide Hospital
North Terrace
ADELAIDE SA 5000
Or fax to: (08) 8222 2883
Or email: rah.consumeradviser@health.sa.gov.au