### DRIVING WELL OCCUPATIONAL THERAPY COMPLAINT REPORTING FORM

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| **Date of report:** |  |
| **Name of person reporting:** |  |
| **Name of team member receiving report:** |  |
| **Was support offered to the person making the complaint?** |  |

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| How this complaint came to the attention of the Provider:  |

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| Date of incident / event relevant to the complaint: |

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| Details of the complaint: (detail if multiple accounts are provided who is reporting and when) |
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**Follow up and next actions:**

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| Date | Details | Staff member |
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| Was support continually provided throughout the resolution process? Yes / No / Declined |
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| Was the person supported to access another service? Yes / No / Declined |
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| Name of alternative Provider: Date of referral: |

Agreement of resolution:

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Signed by person making complaint Signed by staff member

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| Was the complaint referred to the NDIS Commission? Yes / No |
| Date of referral: |
| Details of follow up from the Commission: |
| Date: |
| Name of person completing report: |
| Signature: |