Medicareplus INTERNATIONAL	**CUSTOMER COMPLAINT INTAKE FORM**	Form: F/QA/08/3 Revision: 02 Date: 17/08/2021 SOP: QA/08

Fields marked * are mandatory for a successful investigation

Medicareplus Complaint Reference Number (to be assigned by QA)	
COMPLAINT ORIGINATOR / CUSTOMER DETAILS	
***Method of Customer Contact:**	☐ Phone ☐ Email ☐ Post
***Date of Contact:**	
***Name of Complainant:**	
***Job Title and Department of Complainant:**	
Medicareplus Response Method:	☐ Phone ☐ Email ☐ Post
***Address of Complainant:**	
***Contact Telephone No:**	
***Contact e-mail:**	
***Usage:**	☐ Home Use ☐ Clinic ☐ Other, give details –
***Device Operator at Time of Event:**	☐ User ☐ Patient ☐ Healthcare Professional
PRODUCT INFORMATION	
***Product Code:**	
***Product Description:**	
***Lot / Batch Number/s:**	
Number of identical events with the same Lot / Batch Number:	☐ Unknown If known please specify number:
***Expiry Date:**	
***Quantity:**	

Place of Purchase:	
***Reason for the Complaint:**	
Any unexpected consequences?:	☐ No ☐ Yes, give details –
Product Available for Return? ***For Medi Peak Flow Meters ask for the meter to be returned to Medicareplus wherever possible.***	☐ No ☐ Yes
Photographic Evidence Available?	☐ No ☐ Yes
Has the product been used? ***For Medi Peak Flow Meters only*** ***Did issue occur at first use of the meter?***	☐ No ☐ Yes, is it a biohazard (contaminated)? Give details - ☐ Yes ☐ No, After what period of use, did the issue occur? –

Were there any signs of damage or deterioration of the meter prior to the issue being detected?	☐ No ☐ Yes, give details –	
PROCEDURE INFORMATION		
Procedure Name:		
Procedure Date:		
Procedure Outcome:	☐ Completed with this device / pack ☐ Completed with another device / pack ☐ Completed with a different device / pack ☐ Aborted due to this event ☐ Aborted due to same device / pack unavailable ☐ No information available ☐ Aborted due to another reason Reason:	
Time of Event:	☐ Unpacking ☐ Preparation ☐ Introduction ☐ During Procedure	☐ Withdraw ☐ Procedure Closure ☐ Post Procedure ☐ No information available
***Did the event lead to complications for the user or patient which required medical intervention?**	☐ No	☐ Yes
	If Yes, ☐User	☐ Patient
***If Yes, please provide details of methods of medical intervention required:**		
***Any alleged injuries, hospitalisation, GP referral or deterioration to health reported?:**	☐ No ☐ Yes, give details -	
***Competent Authority Notified?**	☐ No ☐ Yes	

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***Date Reported:**			
***Competent Authority Reference:**			
COMPLETED BY			
***Name:**		***Signature:**	
***Job role:**		***Date:**	
Please forward the completed Customer Complaint Intake Form along with any samples as soon as possible to: Quality Assurance, Medicareplus International Ltd, Chemilines House, Alperton Lane, Wembley, Middlesex, HAO 1DX, United Kingdom. Email: qa@medicareplus.co.uk			