PATIENT FEEDBACK FORM

Your feedback matters to us! The quickest way to raise a concern is to speak to a member of staff. Management would like the chance to resolve your concerns immediately if possible. Alternatively, complete this form return it to the clinic as outlined at the bottom of the form.

1. Your Details

Title: **Given Names:**

Surname:

Are you known by another name: ☐ **Yes** ☐ **No**

Date of Birth:

Preferred Method of Contact:

Post ☐ **Telephone** ☐ **Email** ☐

Postal Address:

City: **State:** **Postcode:**

Daytime Telephone: **Mobile Phone:**

Email:

Are you giving feedback on behalf of another person? **Yes** **No**

Title: **Given Names:**

Surname: ☐ ☐

Are they known by another name:

Date of Birth:

Your relationship to this person:

If you are giving feedback on behalf of someone else, we will need to contact that person before we can review and release information to you.

2. What is the nature of your feedback?

☐ **Compliment** ☐ **Suggestion for Improvement** ☐ **Complaint**

Compliments will be sent to the staff member and their manager! Suggestions will be reviewed and discussed. Complaints will be actioned.

3. Who is your feedback about?

☐ **Administration** ☐ **Sonographer**

Other:

Name, if known:

4. Your Feedback

Tell us DATE it happened, WHAT happened, WHO was involved, WHERE it happened & outline your main concern(s).

Attach another page if you need more space & include copies of any supporting documents—e.g. emails, reports, invoices, etc.

5. Have you previously tried to resolve this issue if it relates to a complaint?

Have you contacted us about your complaint before: ☐ **Yes** ☐ **No**

Date:

How: ☐ **Post** ☐ **Telephone** ☐ **Email** ☐ **In Person**

Who did you contact:

Details:

Outcome:

6. What do you want to happen?

What are you hoping to achieve by providing us with this feedback or alternatively what would you like to see happen as a result of your feedback?

☐ **Concern Acknowledged and registered**

☐ **Apology**

☐ **Review of Procedures/Change in Practice**

☐ **Information required**

☐ **Receive Explanation**

☐ **Intervention/Training with Staff**

☐ **Other:**

7. Privacy & Confidentiality

In managing your feedback, your medical records may need to be reviewed and we will collect personal information about you. We comply at all times with the Australian Privacy Principles & National Health and Medical Research Council Guidelines.

As part of this process we are required to raise your concern with the person(s) you have named as part of a fair and through investigation process. If there is any information you don't want them to receive, please let us know.

We will not disclose personal information unless you consent or the disclosure is allowed, authorised or required by law.

Do you consent for us to access your medical records if required to review your concerns? ☐ **Yes** **No** ☐

Depending on the issue, selecting 'No' may limit our ability to fully review your concern.

8. Declaration

I declare the information provided by me is, to the best of my knowledge, true and correct. I understand and agree that my information will be used to review any concerns and may be given to staff to review.

Signature: **Date:**

9. Return your feedback to us

By Mail/In Person: **Precision Imaging**
Suite 21
Nucleus Medical Suites 23 Elsa
Wilson Drive Buderim Qld 4556

By Email: **info@precisionimaging.net.au**

THANK YOU FOR TAKING THE TIME TO PROVIDE US WITH YOUR FEEDBACK.