MonashHealth

# CONSUMER FEEDBACK FORM

## Person Providing Feedback

We appreciate that at times you and/or the person you are acting on behalf of may wish to remain anonymous. In these cases, an investigation will not be conducted and this information will be used as constructive feedback only.

**Medical Record # (if known)**.....

**Title:** Mr Mrs Miss Master Ms

**First Name:** .....

**Surname:** .....

**Address:**.....

..... **Postcode:** .....

**Phone:** ..... **Mobile:** .....

**Email:** .....

**Primary Language:** .....

**Interpreter Required:** Yes / No

Please indicate if you would be interested in attending an informal meeting with an interpreter present and we will be happy to arrange this. Yes / No

**What is your relationship to the Consumer?**

Child ☐ Friend ☐

Parent ☐ Sibling ☐

Self ☐ Spouse ☐

Other: ☐

Please specify……

## Consumer

(Please complete only if different from the person providing feedback details).

**Medical Record # (if known)**.....

**Title:** Mr Mrs Miss Master Ms

**First Name:**.....

**Surname:** .....

**Address:**.....

.....**Postcode:**.....

**Phone:** .....**Mobile:** .....

**Email:**.....

**Date of Birth:**.....

**Primary Language:**.....

**Interpreter Required:** Yes / No

Please indicate if you would be interested in attending an informal meeting with an interpreter present and we will be happy to arrange this. Yes / No

**If you have the following information, please provide:**

The name of the Ward , Unit, Department or Service:

.....

The name of the treating health professional(s):

.....

**Where was the service provided?**

Casey Hospital ☐

Cranbourne Integrated Care Centre ☐

Dandenong Hospital ☐

Kingston Centre ☐

Monash Children's Hospital ☐

Monash Medical Centre Clayton ☐

Moorabbin Hospital ☐

Monash Health Community Service ☐ Please specify site ……..……..

Mental Health Service ☐ Please specify site……..

**Please provide details of your feedback** including dates, times, location and outcomes. (If more space is required, please add pages).

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**Please advise how you would like us to respond to your feedback:**

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**Signature of Consumer:** _____ **Date:** _____ **/** _____ **/** _____

**Signature of Person Providing Feedback:** _____ **Date:** _____ **/** _____ **/** _____

Upon receipt of your feedback, you will receive an acknowledgement. Please ensure that all of your contact details are correct, as follow up cannot proceed without this.

**Please return the completed form to the relevant Patient Relations Coordinator by mail:**

***Casey Hospital***
*Locked Bag 3000*
***Hallam** 3803*
(8768 1465)

***Dandenong Hospital***
*PO Box 478*
***Dandenong** 3175*
(9554 8078)

***Monash Medical Centre and Monash Children's Hospital***
*Locked Bag 29, **Clayton** 3168*
(9594 2702)

***Monash Health Community***
*PO Box 478*
***Dandenong** 3175*
(9554 8078)

***Kingston Centre***
*Warrigal Road*
***Cheltenham** 3192*
(9265 1356)

***Mental Health Program***
*PO Box 478*
***Dandenong** 3175*
(9554 9237)

***Moorabbin Hospital***
*PO Box 72*
***East Bentleigh** 3165*
(9928 8584)

Thank you for taking the time to provide us with your valued feedback.
Please note that feedback may also be provided by completing the online form available on the Monash Health website.
http://www.monashhealth.org/page/About_Us/Contact_us/