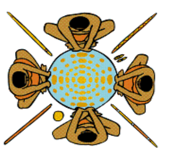

GURRINY YEALAMUCKA
HEALTH SERVICES
ABORIGINAL CORPORATION

YOUR HEALTH YOUR SAY
FEEDBACK FORM

This form is for you to tell us what you really think about our services. It's your health service so we need you to have your say on how we can do things better or tell us when we are getting things right.

Date:______/______/________ **Time:_______:_______**

☐ Complaint ☐ Compliment ☐ Feedback ☐ Improvement Suggestion ☐ Issue ☐ Verbal
☐ Other:……………………………………………………………

Are you:
☐ Client with Appointment ☐ Client Walk-in ☐ Visitor ☐ Staff Member ☐ Service Provider
☐ Other:……………………………………………………

Who did you see today?

☐Community Manager	☐Child Health Team	☐Family Wellbeing
☐Doctor	☐Telehealth	☐SEWB Team
☐Nurse	☐Pharmacy	☐Care Coordination Team
☐Health Worker	☐Women's Health	☐General Support
☐Midwife	☐ Men's Health	☐ Family Healing Service

☐Other/Visiting Services:………………………………………………………………………………

How did you travel to the clinic today?
☐ Gurriny Courtesy Bus ☐ Gurriny Private Vehicle ☐ Own Transport ☐ Other:……………………………………………………

How was your visit today? BAD OK GOOD Very Good Excellent

Did you feel you were given enough time for your visit? ☐Yes ☐NO

Did you get the information you needed? ☐Yes ☐NO

Overall how would you rate Gurriny? BAD OK GOOD Very Good Excellent

Tell us what we could do better/or any further comments:

Would you like us to contact you in regards to this matter? ☐Yes ☐ No
If Yes, please leave your best contact number/details:……………………………………………………………………………………………………