

Central Gippsland Health CONSUMER FEEDBACK FORM

Consumer					Person providing feedback							
Title:	Mr	Mrs	Miss	Ms	Dr	(Please complete only if different from the consumer's details)						
First Name:				We appreciate that at times the person you are acting on behalf of may wish to remain anonymous. If this is the case an investigation will not be conducted and this information will be used as constructive feedback.								
Surnan	ne:					Title:	Mr		Mrs	Ms	Miss	Dr
Address:					First Name:							
Postcode:				Surname:								
Phone:	:		Fax:			Address:						
Email:					Postcode:							
Date of Birth:					Phone: Fax:							
	y of Birth:					Email:						
	ed Langua	-				Date of Birth:						
-	eter Requi		′es/No			Country of Birth:						
	indicate if					Preferred Language:						
attending an informal meeting with an interpreter present and we will be happy to arrange this.					Interpreter Required: Yes/No							
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:				•	Do you have permission from the consumer to make this complaint?							
The name of Ward, Unit or Department:						Yes/No						
The Name of the treating health professional(s):				l(s):	What is your relationship to the Consumer?							
						Spouse			Partner			
						Parent			Child			
						Grandpar	ent		Grandch	ild 🗆		
						Sibling			Guardiar	n 🗆		
						Friend			Observe	r 🗆		
						Other			Please S	Specify:		
	was the S	ervice P	_	_		Ctratta				_		
CGH S			L	_		Stretton Park						
CGH M		Inc	L	-		Wilson Lodge Community Service		_				
neytiel	d Hospital	INC	C	L		Comm	iunity S	Service	3			
Please	specify S	ervice ar	nd Site:									
	Pror	npt Doc No	o:<#doc_n	um> v<#ver	num> E	Entered on PR	OMPT: <	<#issue	date> Un	odated on: <#r	evision issue	date>

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Please provide details of your feed you are welcome to add to this form		n and outcomes (if you	require additional pages		
To enable us to best meet your exp your feedback is only for our inform		ld like a written respon	se to your feedback or if		
Signature of service user:		Date:			
Signature of person finding feedba	ck:	Date:			
Upon receipt of your feedback, an		•	a member of CGH Staff.		
Please ensure that all of your conta	act numbers and address details ha	ave been completed.			
Please return form to:					
Central Gippsland Heath Sale (includes Community Services and Wilson I	Central Gippsland Heath Maffra Lodge)	Stretton Park	Heyfield Hospital Inc		
Central Gippsland Health 155 Guthridge Parade SALE VIC 3850	Central Gippsland Health 48 Kent Street MAFFRA VIC 3860	Stretton Park 1 Kent Street MAFFRA VIC 3860	Heyfield Hospital Inc 14 Licola Road HEYFIELD VIC 3858		
Thank you for taking the time to pro	ovide us with this valued feedback				
Office Use Only	Date Received:	Date of resolution:			
, ,					

 Prompt Doc No: <#doc_num> v<#ver_num>
 Entered on PROMPT: <#issue_date>
 Updated on: <#revision_issue_date>

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Next review due: <#next_review_date>