**Bullinah**

**Client Feedback Form**

**(Please circle the most appropriate answer for you)**

1. If you phone Bullinah for help about your health, do you feel that staff are very helpful in assisting you?

**YES NO SOMETIMES OTHER** (Please specify)

2. Do you feel you were treated with respect by the Staff at Bullinah?

**YES NO SOMETIMES OTHER** (Please specify)

3. Is it easy to understand what Bullinah’s doctors and other clinical staff tell you about your health issues and medicines?

**YES NO SOMETIMES OTHER** (Please specify)

4. Where do you get medical help when Bullinah is closed?

**HOSPITAL OTHER MEDICAL PRACTICE OTHER** (Please specify)

5. If you have a big problem with the Doctor, Nurse or Health Workers can you speak to someone

 else who works at Bullinah?

 **YES NO SOMETIMES OTHER** (Please specify)

6. Do you have concerns regarding confidentiality?

  **YES NO SOMETIMES OTHER** (Please specify)

7. How long have you been using Bullinah Aboriginal Health Service?

 **0-6 months 6-12 months 1-2 years More than 2 years**

8. How old are you? What Gender are you?

 **Under 15 15-30 31-49 50 and over**

 **Female Male**

**9. Have you been offered a Health Check or your children a Child Health Check by Bullinah staff?**

 **YES N**

1. What do you think that Bullinah Health Service does well?

|  |
| --- |
| Please provide your comments below? |

1. What would make Bullinah Health Service a Better Service for the community?

|  |
| --- |
| Please provide your comments below? |

1. What other Services do you think that Bullinah should be providing to the community?

|  |
| --- |
| Please provide your comments below? |

**Name: ..…………………………………………….. Signature: ………………………………………………….**

(Optional) (Optional)

**Date: ………………………….**

**Thank you for completing this Feedback Form.**

|  |  |
| --- | --- |
| **STAFF ONLY** *(CEO/Clinical Service Manager to fill in)* |  |
| Received by: | Date: | Registration No. |
| Action taken: | Date: |
| CEO/Clinical Service Manager Signature:  |