To share your feedback with us you can:

1. Talk to our staff

2. Speak with the manager or person in charge

3. Write to us online at:
health-services.mercyhealth.com.au
or email feedback@mercy.com.au

4. Write to us using this form

5. Contact our Consumer Liaison Officer on 8416 7783
(Mon–Fri or leave a message with a name and contact number)

Tell our staff if you:

- require an interpreter
- want a copy of our feedback form in a language other than English.

Mercy Health
Level 2, 12 Shelley Street
Richmond Vic 3121
Phone: 8416 7777
mercyhealth.com.au

Mercy Health acknowledges Aboriginal and Torres Strait Islander Peoples as the first Australians. We acknowledge the diversity of Indigenous Australia. We respectfully recognise Elders past, present and emerging.

Mercy Health
Consumer Feedback – Health Services
Reply Paid 88673
RICHMOND VIC 3121

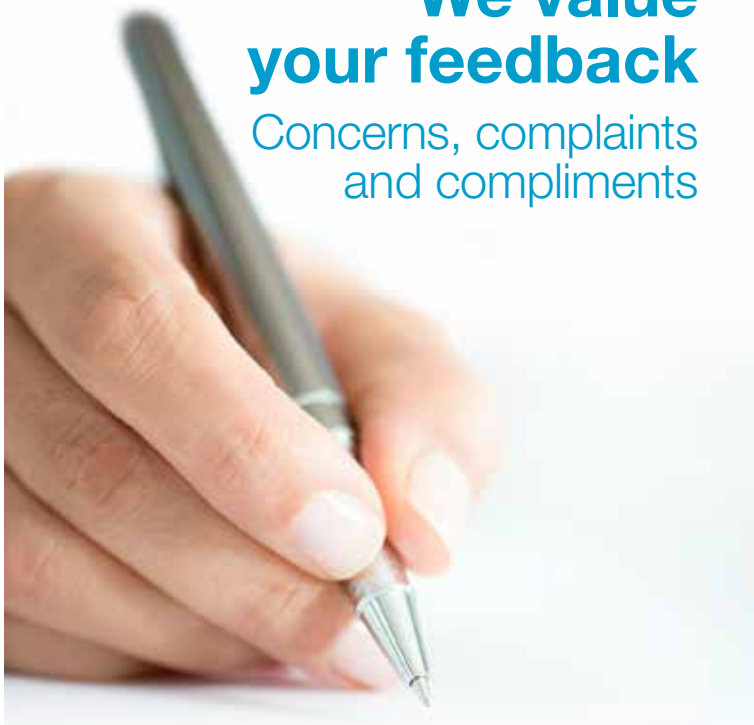
Delivery Address:
Level 2, 12 Shelley Street
RICHMOND VIC 3121

No stamp required if posted in Australia

Mercy Health
Care first

We value your feedback

Concerns, complaints and compliments



Health Services **Feedback form**

Community Reviewed — Making information easier to read.

health-services.mercyhealth.com.au

Today's date ____________________

Thank you for taking the time to submit your feedback. Please write as little or as much as you want.

Our guarantee to you

All comments/suggestions are sent to the relevant areas for discussion and consideration.

We address all complaints and inform you of any actions or decisions we make if requested. You may choose to remain anonymous.

For a response, please supply your contact details at the end of this form.

Do you require a reply to these comments?

- ☐ Yes
- ☐ No

What would you like to see happen as a result of your comments? (Please tick all relevant boxes.)

- ☐ Access to service
- ☐ Apology
- ☐ Change in procedure or policy
- ☐ Explanation
- ☐ Registering my concern
- ☐ Manager notified
- ☐ Other (please specify) ____________________

Location or service:

- ☐ Mercy Hospital for Women
- ☐ Werribee Mercy Hospital
- ☐ Mercy Mental Health
- ☐ Mercy Health O'Connell Family Centre
- ☐ Mercy Palliative Care

Ward/area/department ____________________

Patient/client name ____________________

Patient/client date of birth ____________________

Patient/client ID number (if known) ____________________

Patient/client address ____________________

____________________ Postcode ____________

Contact number ____________________

Email ____________________

Preferred contact method ☐ Phone ☐ Email

Do you identify as Aboriginal or Torres Strait Islander? If yes, please tick below:

- ☐ Aboriginal ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander

Are you the patient/client? ☐ Yes ☐ No

If no, please provide your details

Name ____________________

Contact number ____________________

Email ____________________

The patient/client is my ____________________