PATIENT FEEDBACK FORM

Patient Details:

Full Name: _____

Date of Birth: _____

Contact Number: _____

Email Address: _____

Appointment Details:

Date of Appointment: _____

Doctor/Therapist Name: _____

Feedback:

1. How would you rate your overall experience?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. How satisfied are you with the waiting time?
☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

3. Please rate the professionalism of the staff:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. How clean and comfortable were the facilities?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. Did the healthcare provider explain things clearly?
☐ Always ☐ Usually ☐ Sometimes ☐ Never

6. Additional Comments or Suggestions:

I consent to the use of my feedback for healthcare service improvement purposes. I understand that my personal details will be kept confidential and handled in accordance with Australian privacy laws.

Patient Signature: _____

Date: _____

Privacy Notice:

This feedback form is managed in compliance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles. Your personal information will be used solely for the purpose of improving healthcare services and will not be disclosed to third parties without your consent unless required by law.

Contact for Further Assistance:

If you have any concerns or questions about how your feedback is handled, please contact:

Privacy Officer
Phone: _____
Email: _____

Patient Signature	**Healthcare Provider Signature**
Signature: _____	Signature: _____
Name: _____	Name: _____
Date: _____	Date: _____