"Generations of vibrant, healthy and strong Aboriginal communities."

When Complete, Forward to: **MDAS Quality and Governance Manager**
PO Box 5134
Mildura VIC 3502
03 5018 4100

FEEDBACK (Compliments & Complaints)

Person Providing Feedback				
Full Name				
Date of Birth				
Postal Address				
Email Address				
Telephone Number				
Mobile Number				
Date Feedback Provided				
Do you wish to remain Anonymous	☐	**Yes**	☐	**No**
Do you want to be contacted with a response	☐	**Yes**	☐	**No**
Are you lodging a feedback on behalf of someone else?	☐	**Yes**	☐	**No**
What is relationship to this person?	☐	**Parent**	☐	**Partner**
	☐	**Child**	☐	**Legal representative**
	☐	**Sibling**	☐	**Other**
Do you consent to MDAS accessing your medical records for investigation purposes?	☐	**Yes**	☐	**No**
Indigenous Status	☐	**Aboriginal**	☐	**Both**
	☐	**Torres Strait Islander**	☐	**Neither**

Nature of Feedback *(please tick applicable box)*

☐ **Compliment** ☐ **Comment** ☐ **Complaint** ☐ **Other**________________

Details -

MDAS Program/Service Involved	
Location of Program/Service	

Date of Incident	
Staff members Present/Involved	
Other Witnesses/ People Present	

Details of Incident *(Please ensure you remain factual. If you require more space, please attach additional pages to this form)*

What would you like to see happen as a result of raising these concerns?

- ☐ Apology to be provided.
- ☐ Your concerns are formally registered.
- ☐ To receive a thorough explanation.
- ☐ MDAS undertake a review of its policy
- ☐ A change in practice as a result of your complaint.
- ☐ Intervention or training occurs with staff.
- ☐ Improved access to service or resources for myself or others.

Have you lodged your complaint with another organisation?

☐ Yes ☐ No

If yes please give details of any outcome to date:

I hereby confirm that the information provided on this form is, to the best of my knowledge, a true and correct account of events that occurred in relation to the incident I am raising in my feedback.

Signature:

Date:

If you had help completing this form, please record the name of the person who assisted you	

Next actions	
Complaints	Complete an incident form
Escalation policy	Follow Reporting Escalation Policy.

Office Use Only:

Date Received:
Date Acknowledged:
Investigation Initiated:
Investigation Complete:

Method Received:
Manager Notified:
Investigation Conducted:
Submitter Advised of Outcome

Entered into CHARM:
Investigation Required: