May Shaw
Health and Aged Care for Living

Feedback Form

We would love to hear from you

Compliment ◯ Complaint ◯ Suggestion ◯

Date: ____/____/____

Your details are optional

Name: _____

Would you like to be contacted about your complaint?

Yes ◯ No ◯

How would you like to be contacted?

Phone ◯ Email ◯ In person ◯

Contact details:

_____

If this is in relation to a client/resident?

Their Name: _____

What is your relationship with the person receiving care?

Nok/family ◯ Doctor ◯

Visitor ◯ Staff ◯

Friend ◯ Other ◯

Resident ◯ Client ◯

Is the person receiving care aware of this feedback?

Yes ◯ No ◯ N/A ◯

Please provide details about your feedback:

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