Cairns and Hinterland Hospital and Health Service welcomes your feedback about your experience with us. Your compliments, complaints and suggestions help us provide the best possible service we can to our patients and families.

We encourage you to provide feedback in person at the **point of care in the first instance** so our staff can respond immediately. If you wish to formalise your complaint, you are welcome to use this form. Other contact options are listed on the back of this form.

This is a:  
☐ Compliment  
☐ Suggestion/idea  
☐ Complaint/concern

Are you a:  
☐ Patient  
☐ Parent/carer/guardian  
☐ Other *(please specify below)*

Would you like us to contact you about your feedback and advise you of any updates or action taken?

☐ Yes  
☐ No

If yes, please provide your details below.

Your name: ____________________________

Tel: (H) ____________________________

Tel: (M) ____________________________

Email: ____________________________

Address: ____________________________

Postcode: ____________________________

Patient’s name: *(if applicable)*

Patient’s date of birth: ___/___/____

Patient’s UR number: *(if known)*

What would you like to see happen as a result of your feedback?

*Tick (☑) as many boxes as appropriate*

**Compliment**

☐ Thank staff member/team

☐ Other *(please specify below)*:

**Complaint**

☐ Apology

☐ Explanation

☐ Improved access to service

☐ Change in procedure/policy

☐ Education/training of staff

☐ Prevent reoccurrence

☐ Other *(please specify)*:

Please complete both sides of this form

Your privacy: We take your privacy seriously. There will be no record of your complaint attached to the patient’s medical chart. All complaints are treated with the utmost confidentiality at all times. Compliments will be forwarded to relevant staff and their supervisors.
Tell us how we are doing

Please provide as much detail about your experience as possible (e.g. name of ward/area, time, staff names). If there is not enough space, please attach another sheet of paper.

Date event occurred: Facility: (eg. Cairns Hospital, Smithfield Community Health etc.)

___/___/_____ ________________________________

Ward/department/service: (eg. Outpatients, Emergency etc.) ________________________________

Details:

Thank you for your feedback

Please return completed form by:

Handing to any staff member

Mailing to:

CHHHS Patient Liaison Office
PO Box 902
Cairns Q 4870

Emailing to: CHHHS_feedback@health.qld.gov.au

07 4226 6864 or 07 4226 8244
(Mon to Fri 09:00-15:00)

Please tick if you require:

☐ an interpreter (please specify language required)

☐ an Aboriginal and Torres Strait Islander Liaison Officer