We value your opinion about your experience of our commissioned services. The feedback you provide will help us to review and continually improve our commissioned services. Completing this survey is voluntary and will not affect the care you receive. All responses are confidential and will only be used for quality improvement purposes. To maintain your confidentiality, please do not write your name on this survey.

Please indicate the service you were involved with:

|  |  |
| --- | --- |
|[ ]  Psychological Strategies (formerly known as ATAPS) |[ ]  Aboriginal and Torres Strait Islander Service |
|[ ]  Bushfire & Post Traumatic Stress Service |[ ]  Perinatal Depression Service |
|[ ]  Child Mental Health Service |[ ]  Suicide Prevention Service |
|[ ]  Mental Health Nurse Incentive Program |[ ]  Partners in Recovery |
|  |  |[ ]  Other |

Please indicate the name of your service provider:

How long (or how many sessions) have you been involved in this service for?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Agree | Neither Agree or Disagree | Disagree | Not Applicable |
| The process of making the first appointment worked well |[ ] [ ] [ ] [ ]
| The waiting time for my first appointment was suitable |[ ] [ ] [ ] [ ]
| I felt understood by my service provider |[ ] [ ] [ ] [ ]
| I have benefited from the service |[ ] [ ] [ ] [ ]
| I felt comfortable to use the service |[ ] [ ] [ ] [ ]
| My privacy and confidentiality was upheld in this service |[ ] [ ] [ ] [ ]
| The communication between my service provider and GP was useful |[ ] [ ] [ ] [ ]
| I feel my service provider would welcome any feedback I have |[ ] [ ] [ ] [ ]
| I would be willing to be referred again if the need arose |[ ] [ ] [ ] [ ]
| I am aware of my rights to express concerns about any aspect of this service |[ ] [ ] [ ] [ ]

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| Overall, how would you rate your wellbeing improvement with the program? |
| [ ] Not at all | [ ] Slight | [ ] Moderate | [ ] Significant | [ ] Major |

Please tick the component(s) your health provider addressed well:

|  |
| --- |
|[ ]  Listen to my story |
|[ ]  Help me understand my concerns better |
|[ ]  Helped my family understand my concerns |
|[ ]  Worked with me to set goals and plan strategies to achieve them |
|[ ]  Supported me to make changes in my life |
|[ ]  Connected with me personally |
|[ ]  Advocated on my behalf |
|[ ]  Linked me with other helpful services |
|[ ]  Helped my GP support me better |
|[ ]  Helped me understand new skills |
|[ ]  Helped me explore and make sense of my feelings and thoughts |

|  |
| --- |
| What does this service or your health provider do well? |
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| --- |
| What could be improved? |
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| --- |
| Any other comments? |
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|  |

Thank you for your feedback.

Please send this completed form to Kallisteni Costas by fax: 9879 5407 or email to Kallisteni.costas@emphn.org.au .
If you have any queries, please don’t hesitate to contact Eastern Melbourne PHN on 9046 0300.