PATIENT SUGGESTION FORM

We care about you and your opinion
Help us improve our care by sharing your feedback and suggestion

Patient Information(optional):

- Full Name: ______________________________
- Date of Birth: ______________________________
- Contact Number: ______________________________
- Email Address: ______________________________

Visit Details:

- Date of Visit: ______________________________
- Time: ______________________________
- Department: ______________________________

Suggestion for Improvement: Please provide details and any suggestion you have for how we can improve our services:

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Rate Your Experience: Please rate the following aspects of your experience on a scale of 1 to 5, with 1 being Poor and 5 being Excellent. Circle the selected number.

- Quality of Care: [1] [2][3][4][5]
- Communication: [1] [2][3][4][5]
- Cleanliness: [1] [2][3][4][5]
- Waiting Time: [1] [2][3][4][5]
- Staff Friendliness: [1] [2][3][4][5]

Permission to Contact: May we contact you for further clarification or follow-up regarding your feedback?

- □ Yes
- □ No

If Yes, Contact Preference: How would you prefer to be contacted regarding your feedback?

- □ Phone
- □ Email (send a copy or scan of the filled form to email address: complaints@sehcf.org