**FORT PECK SERVICE UNIT INDIAN HEALTH SERVICE**

“WE CARE” Tell us how we did today!

Please rate the areas you visited today. FILL in the correct square. Comments may be written on the back. Providing personal information is voluntary and will only be used to contact you in order to respond to your complaints, inquiries or comments.

Which clinic did you visit? □ Poplar □ Wolf Point

Response Definition: 1 – Unsatisfactory; 2 – Below Average; 3 – Average; 4 – Above Average; 5 - Outstanding

1 2 3 4 5

Administration………………………………………………………………………………………. □ □ □ □ □

Appointment Desk……………………………………………………………………………….. □ □ □ □ □

Audiology…………………………………………………………………………………………….. □ □ □ □ □

Behavioral Health……………………………………………………………………………….. □ □ □ □ □

Benefits Coordinator………………………………………………………………………….. □ □ □ □ □

Business Office…………………………………………………………………………………… □ □ □ □ □

Case Management………………………………………………………………………………. □ □ □ □ □

Purchased Referred Care (formerly CHS)………………………………………… □ □ □ □ □

Dental………………………………………………………………………………………………… □ □ □ □ □

Information Desk / Switchboard……………………………………………………… □ □ □ □ □

Lab…………………………………………………………………………………………………… □ □ □ □ □

Medical Providers……………………………………………………………………………… □ □ □ □ □

Medical Clinic Nurses and Assistants………………………………………………… □ □ □ □ □

Medical Records………………………………………………………………………………… □ □ □ □ □

Optometry…………………………………………………………………………………………… □ □ □ □ □

Patient Registration…………………………………………………………………………… □ □ □ □ □

Pharmacy…………………………………………………………………………………………… □ □ □ □ □

Public Health Nursing………………………………………………………………………… □ □ □ □ □

Radiology…………………………………………………………………………………………… □ □ □ □ □

Environment Appearance Outside / Inside……………………………………… □ □ □ □ □

**FORT PECK SERVICE UNIT INDIAN HEALTH SERVICE**

“WE CARE” Tell us how we did today!

What Medical Team are you on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did your Team perform today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be contacted about any concerns? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No

Comments:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BELOW THIS IS FOR INTERNAL USE ONLY

Date Received by Risk Management Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assigned Tracking Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Referred on for further investigation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Investigation Completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Returned to Risk Management Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complainant Contacted on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Closed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Phone □ Letter □ Email

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0036. The time required to complete this information collection is estimated to average three minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.