

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.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appointment Desk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Audiology.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benefits Coordinator.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Business Office.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Management.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purchased Referred Care (formerly CHS).....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information Desk / Switchboard.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Providers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Clinic Nurses and Assistants.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Records.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optometry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Registration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Health Nursing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environment Appearance Outside / Inside.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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"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.