

Population and Public Health Individual and Family Client Feedback Form

Please share your experiences with Public Health services in Winnipeg. Your feedback will be used to improve Public Health services and programs. Your feedback is anonymous.

1. Date of service: _____

2. What Public Health service did you receive? (Check one)

- | | | |
|--|---|---|
| <input type="checkbox"/> Support before birth | <input type="checkbox"/> Infant Nutrition Class | <input type="checkbox"/> Travel Health (<i>Including Rabies Occ Health</i>) |
| <input type="checkbox"/> Support after birth | <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Breastfeeding Support Group | <input type="checkbox"/> Street Connections | |

3. For each item below, please check the box that best describes your most recent experience.	Strongly Agree	Agree	Disagree	Strongly Disagree
a. I received the service or information I needed.				
b. The information I received was clear and easy to understand.				
c. I received useful information.				
d. Staff understood my needs.				
e. Staff were friendly and polite.				
f. I felt respected in making my own choices and decisions.				
g. I was able to access services in a timely way.				
h. The clinic hours were convenient for my schedule.				
i. I would recommend this clinic to others.				

Overall: How satisfied were you with the services or information you received?	Very Satisfied	Satisfied	Dissatisfied	Very dissatisfied
	□	□	□	□

4. Is there anything else you would like to share about your most recent experience?

5. Where did you receive Public Health services? (Please check one)

- | | |
|---|--|
| <input type="checkbox"/> Home | <input type="checkbox"/> In the community (e.g., community centre) |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Office (e.g., Public Health office, Access Centre) | |

6. What is your postal code? _____

7. What is your age?

- | | | | |
|------------------------------------|--------------------------------|--------------------------------|---|
| <input type="checkbox"/> <15 years | <input type="checkbox"/> 20-24 | <input type="checkbox"/> 30-39 | <input type="checkbox"/> prefer not to answer |
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 25-29 | <input type="checkbox"/> >40 | |

8. What is your gender?

- Male
 Female
 Other _____
 Prefer not to answer

Thank you for sharing your experience in receiving Public Health Services.

If you would like to speak with someone about your experience, please contact WRHA Client Relations at 204-926-7825 or email ClientRelations@wrha.mb.ca

Office Use Only: Community Area/Team: _____ Filled in by: ___ Client ___ Staff ___ Volunteer ___ Translator _____
 Neighborhood (based on cross ref to 6 dig PC) _____