

REFERRAL FEEDBACK FORM

We would appreciate feedback on the referral that we gave you. Your response will be kept confidential, and if you have any specific complaints or concerns about the referral, please speak to one of the staff.

1. Name of the physician or agency you visited:
2. What was the purpose of the referral?
3. Did you have any difficulty getting an appointment? If so, please comment.
4. Were the fees for the services provided acceptable and affordable? If not, please explain.
5. Were you satisfied with the care provided by the staff/physician? Yes No
If not, please explain:

Were all of your questions answered? Yes No Comments:

6. Would you like someone on the family planning staff to contact the referral regarding any of your comments? Yes No Other comments or suggestions:

DATE:

NAME (*optional*):