



Complaints, Feedback & Compliments Form

What is your name:

What would you like to tell us? (Please attach if not enough room)

Have you spoken to anyone at LWB about this? If so, who did you speak to and what did they do about it?

What would you like to change or to happen?

How can we contact you?

Where do you live? (address)

Are you a client?

- Yes No

If 'Yes', what services does LWB provide to you?

Life Without Barriers – Office Use Only

Received by:

Date:

LWB Program:

- Out of Home Care CYF Disability Aged Care Mental Health
- NISS AOD

State:

- TAS VIC NSW / ACT SA QLD NT WA

Region:

i-Sight Number:

Manager:

Date Entered: