LIFE WITHOUT BARRIERS

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 (Manager or Team Leader to enter details on i-Sight)			
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			
Follow up: *enter into i-Sight & confirm complaint form attached to event* *Y* ☐ *N* ☐		**i-Sight Number**	
Manager		**Date Entered**	