

## County of San Bernardino Department of Behavioral Health

### Consumer Comment Card

Interpreter Name: \_\_\_\_\_ Date: \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Circle your answer to each question below.

1. Was the interpreter present for the entire service?

Yes

No

2. Did the interpreter say everything you wanted to say?

Yes

No

Unsure

3. How easy was the interpreter to understand?

1	2	3	4
Very easy	Easy	Difficult	Very difficult

4. How comfortable were you with the interpreter?

1	2	3	4
Very comfortable	Comfortable	Somewhat comfortable	Not comfortable at all

Other comments:

**County of San Bernardino  
Department of Behavioral Health**

Mail to: Department of Behavioral Health  
Office of Cultural Competence & Ethnic  
Service  
Mail Code: 0026

**Instructions for DBH Staff:** Please fill out the top two rows of information. Ask Consumer to complete and return the form to DBH Staff. When completed place the pre-addressed form in interoffice mail.