**Patient Satisfaction Survey**

This form contains a list of questions about your visit today. Your answers will be kept entirely confidential and will not be shown to the doctor/nurse/health worker, so feel free to say what you wish. Do not put your name on the form. Please place this form in the locked box at reception before you leave today. Thank you for your help.

**Some information about you: Gender:**

Male

Female

Other

**Your age:**

Under 18

18-30

31-40

41-50

51-60

Over 60

**Are you:**

A new patient A returning patient

**Ethinicity**

**My first language is:**

**In general my health is:**

Poor

Fair

Good

Very good

Excellent

**I saw my regular doctor today:**

Yes No

**Please rate the following:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| YOUR VISIT WITH THE PROVIDER:(Doctor, Physician Assistant, NursePractitioner) | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Does Not Apply |
| I was totally satisfied with my visit to thedoctor today |  |  |  |  |  |  |
| I had enough time with the doctor today |  |  |  |  |  |  |
| The doctor listened to me well |  |  |  |  |  |  |
| I was satisfied with the information given tome today |  |  |  |  |  |  |
| I felt comfortable discussing my issues with the doctor |  |  |  |  |  |  |
| The doctor examined me thoroughly |  |  |  |  |  |  |
| The examination/procedure was made ascomfortable as possible |  |  |  |  |  |  |
| The doctor was respectful of my opinions and beliefs |  |  |  |  |  |  |
| I understand my illness better after seeing the doctor today |  |  |  |  |  |  |
| I was involved in choosing my treatments |  |  |  |  |  |  |
| The doctor gave me good information about improving my health |  |  |  |  |  |  |
| The doctor understands how my conditionaffects my life |  |  |  |  |  |  |
| I can trust this doctor with my private health concerns |  |  |  |  |  |  |
| The doctor explained what could go wrong |  |  |  |  |  |  |
| The doctor involved me in the follow up arrangements |  |  |  |  |  |  |
| The doctor explained the purpose of tests,medications and treatments |  |  |  |  |  |  |
| I would see this doctor again and recommend this doctor to friends and family |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| YOUR APPOINTMENT: | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Does Not Apply |
| I could get an appointment at a time that suited me |  |  |  |  |  |  |
| I could access this clinic with ease (steps/ramps etc) |  |  |  |  |  |  |
| The waiting room was suitable for me |  |  |  |  |  |  |
| The number of days I wait for a routine appointment is ok |  |  |  |  |  |  |
| I can usually book with the doctor of my choice |  |  |  |  |  |  |
| I like to receive appointment reminders |  |  |  |  |  |  |
| The consultation length was suitable for my needs |  |  |  |  |  |  |
| I can get a referral easily when I need one |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| OUR STAFF: | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Does Not Apply |
| Were professional in dealing with me |  |  |  |  |  |  |
| Were considerate of my needs when booking my appointment |  |  |  |  |  |  |
| Were respectful and polite |  |  |  |  |  |  |
| Looked after my confidentiality and privacy |  |  |  |  |  |  |
| Were helpful with billing/insurance questions |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| OUR COMMUNICATION WITH YOU: | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Does Not Apply |
| My phone calls are answered promptly |  |  |  |  |  |  |
| Getting advice or help when needed duringoffice hours is easy |  |  |  |  |  |  |
| Explanation of my procedure was good (if applicable) |  |  |  |  |  |  |
| My test results are reported in a reasonable amount of time |  |  |  |  |  |  |
| Our health information materials are helpful |  |  |  |  |  |  |
| We return your calls in a timely manner |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| OUR FACILITY: | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Does Not Apply |
| Hours of operation convenient for you |  |  |  |  |  |  |
| Overall comfort |  |  |  |  |  |  |
| Adequate parking |  |  |  |  |  |  |
| Signage and directions easy to follow |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| YOUR OVERALL SATISFACTION WITH: | Very Satisfied | Satisfied | Neutral | Unsatisfied | Very Unsatisfied | Does Not Apply |
| Our practice |  |  |  |  |  |  |
| The quality of your medical care |  |  |  |  |  |  |
| Overall rating of care from your provider or nurse |  |  |  |  |  |  |

**Would you recommend the provider to others?**

Yes No

**If no, please tell us why?**

**Do you have any comments or suggestions about the practice?**

**What else could we do to improve your care?**

**Do you have any other comments?**