



Name: _____
(optional)

Procedure(s): _____
(optional)

P A T I E N T S A T I S F A C T I O N S U R V E Y

Your opinion means a great deal to us. We care what you think. We want your experience to be the best it can. We think that means the friendliest, most responsive staff providing personal, professional service. But, what do YOU think? Won't you please take a few minutes of your time and let us know what you like (or don't like) about our services? Any comments would be appreciated. Thank you for your assistance.

KEY: 5 = STRONGLY AGREE, 4 = AGREE, 3 = NOT SURE, 2 = DISAGREE, 1 = STRONGLY DISAGREE

#		5	4	3	2	1
1	The Center was easy to locate and signs within the building were clear					
2	The waiting time for your procedure was reasonable					
3	Forms that you signed were explained to you					
4	You were cared for efficiently and competently					
5	Your doctor spoke with you following your procedure					
6	Your questions, if any, were answered by the nursing staff					
7	Your questions, if any, were answered by the doctor					
8	Signs and symptoms of possible problems that may occur at home were explained to you					
9	If you had take-home prescriptions, they were explained to you					
10	You understood how to take care of yourself at home					
11	If problems occurred at home, you knew whom to call					
12	Your privacy was provided for and respected					
13	You felt you were treated with respect and courtesy at all times					
14	Financial responsibility for your procedure was made clear					
15	You were aware of infection prevention procedures such as handwashing					
16	You felt safe during and after your procedure (if less than 3 please comment below)					

COMMENTS: (Please use the space below to provide us suggestions that you feel would help us improve the care we provide.)

Thank You