It was our pleasure to serve you! Thinking about you and your family member’s visit, how would you rate our facility on the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Excellent | Very Good | Good | Fair | Poor |
| 1. Information and instructions given to you before your procedure |  |  |  |  |  |
| 1. Registration staff explanations about billing and insurance information |  |  |  |  |  |
| 1. Information given to you regarding the potential risks/complications of anesthesia you received. |  |  |  |  |  |
| 1. Courtesy and professionalism of the nursing staff toward you and your family member/care giver. |  |  |  |  |  |
| 1. Level of personal interest and care you received from your doctor. |  |  |  |  |  |
| 1. Protection of confidentiality and personal privacy. |  |  |  |  |  |
| 1. Management of pain after your procedure. |  |  |  |  |  |
| 1. Instructions given to you upon discharge. |  |  |  |  |  |
| 1. Cleanliness and comfort of the facility. |  |  |  |  |  |
| 1. Your overall experience and the care you received at our facility. |  |  |  |  |  |

1. Did you experience any unexpected problems after your procedure? Yes  No

If yes, please explain Click here to enter text.

1. What did you like most about the facility? Click here to enter text.
2. What did you like least about the facility? Click here to enter text.
3. Would you recommend the facility to your family and friends?

Definitely Yes  Probably Yes  Probably Not  Definitely Not

1. Please list any general comments, suggestions, or employee who provided exceptional service. Click here to enter text.
2. Type:  Surgical  Colonoscopy/Endoscopy  Pain Management  Other: \_\_\_\_\_
3. Date of procedure: Click here to enter a date.
4. Name (optional): Click here to enter text.
5. Doctor’s Name (optional): Click here to enter text.