Patient Survey

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

1. **Information and instructions given to you before your procedure.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

2. **Registration staff explanations about billing and insurance information.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

3. **Information given to you regarding the potential risks/complications of type of anesthesia you received.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

4. **Courtesy and professionalism of the nursing staff toward you and your family member/care giver.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

5. **Level of personal interest and care you received from your doctor.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

6. **Protection of confidentiality and personal privacy.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

7. **Management of pain after your procedure.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

8. **Instructions given to you upon discharge.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

9. **Cleanliness and comfort of the facility.**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

10. **Your overall experience and the care you received at our facility.**
    - Excellent
    - Very Good
    - Good
    - Fair
    - Poor

11. **Did you experience any unexpected problems after your procedure?**
    - Yes
    - No
    If yes, please explain,

12. **What did you like most about the facility?**

13. **What did you like least about the facility?**

14. **Would you recommend the facility to your family and friends?**
    - Definitely
    - Probably
    - Probably Not
    - Definitely Not

15. **Please list any general comments, suggestions or employee who provided exceptional service.**

   Type:  □ Surgical  □ Colonoscopy/Endoscopy  □ Pain Management  □ Other: __________

   Date of Procedure: ____________________________

   Name (Optional): ____________________________

   Doctor’s Name (Optional): ____________________________