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| <Organization name> <and /or logo> | | | |
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| **We want to know what you think!** | | | |
| Dear Patient or Caregiver,   1. Please complete this short survey as part of our continuous quality improvement efforts. Your responses will be confidential. 2. Drop your completed survey into the collection box at the registration area as you leave, or mail it back to the address provided below. 3. If you need help completing the form or have questions, please ask the front desk staff. | | | |
| 1. Did you get today’s appointment scheduled as soon as you needed? | ❑ Yes | ❑ No | ❑ Not sure |
| 2. Did your provider listen carefully to you today? | ❑ Yes | ❑ No | ❑ Not sure |
| 3. Did your provider spend enough time with you today? | ❑ Yes | ❑ No | ❑ Not sure |
| 4. Did your provider ask you about changing any of your prescription medications? | ❑ Yes | ❑ No | ❑ Not sure |
| 5. If your provider gave you written instructions or other information today, is it easy to understand? | ❑ Yes | ❑ No | ❑ Not  applicable |
| 6. Did your provider or nurse talk to you today about the exercise or physical activity you receive? | ❑ Yes | ❑ No | ❑ Not sure |
| 7. In general, would you rate your overall emotional health very good? | ❑ Yes | ❑ No | ❑ Not sure |
| 8. In the past year, have you seen a provider three or more times for the same condition or problem? | ❑ Yes | ❑ No | ❑ Not sure |
| 9. On a scale of 1 to 5 with 5 being the best, would you rate your provider a 5? | ❑ Yes | ❑ No | ❑ Not sure |
| 10. If your provider referred you to a specialist, such as a surgeon or a doctor to care for your heart, will you make an appointment right away? | ❑ Yes | ❑ No | ❑ Not sure |
| **Thank you! Your input is very important to us.**  Please drop this in the collection box at <location>, or mail in the attached envelope to:  <Name><Address> <City, State, Zip code> | | | |

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