PATIENT SATISFACTION SURVEY

We thank you for giving us the opportunity to care for you. We hope your experience was a positive one and that you are well on your way to recovery.

It is our mission to provide the highest quality of surgical services, considerate of the specific needs of our patients. Your comments and suggestions are very important to us. Please assist us in continuing to provide the best care possible by completing this short survey. Please check the box which best describes the quality of your experience at this facility.

Scale Definition: 1-Poor 2-Below Average 3-Average 4-Good 5-Excellent N/A-Not Applicable

		1	2	3	4	5	N/A
1.	Pre-Admission testing telephone call or visit	☐	☐	☐	☐	☐	☐
2.	Reception and registration process	☐	☐	☐	☐	☐	☐
3.	Care provided by the nursing staff in the Pre-Operative area	☐	☐	☐	☐	☐	☐
4.	Interaction with the anesthesia staff	☐	☐	☐	☐	☐	☐
5.	Care provided by staff in the operating room	☐	☐	☐	☐	☐	☐
6.	Care provided by the recovery and discharge nursing staff	☐	☐	☐	☐	☐	☐
7.	Protection of your privacy	☐	☐	☐	☐	☐	☐
8.	Your sense of safety and security while at our Center	☐	☐	☐	☐	☐	☐
9.	Cleanliness and appearance of the Center	☐	☐	☐	☐	☐	☐
10.	Your overall confidence in the care provided to you	☐	☐	☐	☐	☐	☐

Please check the box to indicate YES or NO to the following questions

		YES	NO
11.	Did you receive discharge instructions?	☐	☐
12.	Were the instructions clear?	☐	☐
13.	Would you recommend the Center to family members or friends?	☐	☐

Please submit your written responses to the following questions in the boxes provided below.

What did you like best about your experience at the Center?

What did you like least about your experience at the Center?

Any other comments?

Thank you for helping us to improve the services we provide to our patients and their families.

Date of procedure: ______________________

Surgeon's name: ______________________

Patient's name (optional): ______________________