



## **PATIENT SATISFACTION SURVEY**

We want to thank you for giving us the opportunity to care for you. It is important to us to know how our care impacted you and your guests. Your input is greatly appreciated, and we would like to request a few minutes of your time to fill out the following survey. Please rate your experience in the following areas on a scale of 1 to 4, as follows:

| <b>1</b><br><b>Strongly Disagree</b> | <b>2</b><br><b>Disagree</b> | <b>3</b><br><b>Agree</b> | <b>4</b><br><b>Strongly Agree</b> |
|--------------------------------------|-----------------------------|--------------------------|-----------------------------------|
|--------------------------------------|-----------------------------|--------------------------|-----------------------------------|

Please select the surgery or procedure type:      ☐ ENT      ☐ Other

**Registration:**

|  |   |   |   |   |
|--|---|---|---|---|
| 1. Was the Center easy to locate?                              | 1 | 2 | 3 | 4 |
| 2. Was the registration process easy?                          | 1 | 2 | 3 | 4 |
| 3. Was the registration staff courteous, helpful and friendly? | 1 | 2 | 3 | 4 |
| 4. Was the waiting area comfortable?                           | 1 | 2 | 3 | 4 |

**Pre-Operation:**

|  |   |   |   |   |
|--|---|---|---|---|
| 1. Was the Preop area comfortable?               | 1 | 2 | 3 | 4 |
| 2. Was the Preop staff courteous and helpful?    | 1 | 2 | 3 | 4 |
| 3. Skill of the Nurse starting the IV?           | 1 | 2 | 3 | 4 |
| 4. Courtesy/Professionalism of your Surgeon?     | 1 | 2 | 3 | 4 |
| 5. Courtesy/Professionalism of Anesthesiologist? | 1 | 2 | 3 | 4 |

**Operating Room:**

|  |   |   |   |   |
|--|---|---|---|---|
| 1. Did the O.R. staff make you feel comfortable and at ease with your procedure? | 1 | 2 | 3 | 4 |
| 2. Was the O.R. staff courteous, helpful and friendly?                           | 1 | 2 | 3 | 4 |

**Recovery/Discharge:**

|   |   |   |   |   |
|---|---|---|---|---|
| 1. Were your questions answered to your satisfaction?                     | 1 | 2 | 3 | 4 |
| 2. Were the instructions about your procedure and follow-up care helpful? | 1 | 2 | 3 | 4 |
| 3. Was the staff in this area courteous, helpful and friendly?            | 1 | 2 | 3 | 4 |
| 4. Degree to which your pain was controlled?                              | 1 | 2 | 3 | 4 |

**Facility:**

|   |   |   |   |   |
|---|---|---|---|---|
| 1. Overall, was your experience with the Surgery Center positive? | 1 | 2 | 3 | 4 |
| 2. Degree to which the staff worked together to care for you?     | 1 | 2 | 3 | 4 |
| 3. Likelihood of your recommending our ASC to others?             | 1 | 2 | 3 | 4 |

***Have you been a patient at this center before?***      YES      NO

Any additional comments would be greatly appreciated. We continue to assess your feedback. Please continue on the back of this form if necessary. Thank You.

Name of staff member that you would like to recognize? \_\_\_\_\_

**Survey Completed by:**      ☐ **Patient Name (optional):** \_\_\_\_\_

☐ **Other: Relationship:** \_\_\_\_\_

**Procedure Date:** \_\_\_\_\_