Your Choice of a Logo can Appear Here

Floor _____ Date_____

The quality of your experience as a patient is very important to us. Please take a few moments to help us improve our services by responding to this short survey about your care.

On a scale from 1-5 (1 being "Poor" and 5 being "Excellent") please indicate your experience.

1. How well did our staff treat you with courtesy and respect?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

2. How well did our nurses treat you with courtesy and respect?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

3. How carefully did staff listen to you and explain things in a way you could understand?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

4. After you pressed the call button, how well did you get help as soon as you wanted it?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

5. How well was the area around your room kept quiet at night?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

6. How well were your room and bathroom kept clean?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

7. How carefully did your doctors listen to you and explain things in a way you could understand?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

8. How well were you provided teaching about your medications, procedures and discharge?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

9. If you needed medication for pain, how well was your pain controlled?
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

10. How readily did staff members use the phrase, "Is there anything else I can do for you?"
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

11. Would you recommend this hospital to your family and friends? Y = Yes N = No
Y ◯ N ◯

12. Would you like for a hospital representive to contact you? Y = Yes N = No
Y ◯ N ◯

Name: (optional)_____
Phone: (optional)_____
Comments: _____
_____

Please return this to the box at the Nursing Desk

Form ID: Hospital Eval

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Feed this end into scanner slot with printed side facing collection tray.

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