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PATIENT SATISFACTION SURVEY

EMERGENCY DEPARTMENT

Name (Optional):___________________________________ Date of Visit: ___________________________

Dear Patient:

Preston Memorial Hospital is constantly seeking to improve services. Because you recently visited our Emergency Department, we are asking for your help. This survey is part of an ongoing effort to understand how patients view their hospital experience. We hope that you will take the time to complete this survey. Your participation is greatly appreciated. After you have completed the survey, please return it in the enclosed postage free envelope. Your answers will be shared with the Emergency Department staff for purposes of quality improvement. **Your response is confidential**.

PLEASE MARK ONE OF THE BOXES INDICATING YOUR RATING OF THE CARE YOU RECEIVED.

	VERY GOOD	GOOD	FAIR	POOR	VERY POOR	DOES NOT APPLY
YOUR ARRIVAL						
How would you rate the **courtesy and respect** given to you by the person who took your personal/ insurance information?						
How would you rate the **appearance and comfort** of the waiting room?						
YOUR CARE FROM NURSES						
How well did your nurses treat you with **courtesy and respect?**						
How well did your nurses **listen carefully to you?**						
How well did your nurses **explain things** in a way you could understand?						
How well did your nurses **keep you informed**?						

	VERY GOOD	GOOD	FAIR	POOR	VERY POOR	DOES NOT APPLY
YOUR CARE FROM DOCTORS						
How well did your doctor treat you with **courtesy and respect?**						
How well did your doctors **listen carefully to you?**						
How well did your doctors **explain things** in a way you could understand?						
How well did your doctors **keep you informed**?						
OTHER CARE						
How would you rate the **courtesy and respect given to you** by the person who took your blood?						
How would you rate the **courtesy and respect given to you** by the person who performed your radiology tests?						
How would you rate the **wait times** for your tests?						
How well did someone **explain** to you why you needed these tests?						
How well did someone **explain the results** of the tests to you?						
OTHER						
How well were you **kept informed** about delays?						
How would you rate the staff's **sensitivity** to your fears and concerns?						
How well was your **pain controlled**?						
OVERALL ASSESSMENT						
How would you rate your **overall care**?						
How would you rate the **amount of time** spent in the Emergency Department?						
How would you rate how well the nurses and doctors **worked together**?						
Did you know **who to call** if you needed help or had more questions **after you left the hospital**?						

	VERY GOOD	GOOD	FAIR	POOR	VERY POOR	DOES NOT APPLY
Did you get **all the services** you needed?						
If you were sent home, how well did someone **explain** such things as how to take your medicine and how to get follow-up care if needed?						

How long did you have to wait to be seen by a physician? ***(Mark time closest to your wait time.)***

❑ Immediately ❑ Less than 15 minutes ❑ 30 minutes ❑ 1 hour

❑ 1 to 2 hours ❑ 3 to 4 hours ❑ More than 4 hours

How likely are you to recommend our Emergency Department to your family and friends?

❑ Highly Likely ❑ Likely ❑ Neutral ❑ Unlikely ❑ Highly Unlikely

General Comments and Suggestions:

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Do you wish to be contacted? ____Yes ____No

If you would like to be contacted, please leave your telephone number and best time to call:

Your phone number:________________________________ Best Time to Call:___________________