



Patient Satisfaction Questionnaire

SURGERY DATE: _____

PHYSICIAN: _____

To help us in providing the best possible care, we invite you to share your comments and suggestions. Thank you for your time in filling out this survey.

	Excellent	Average	Poor
Ease of Admission.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The facility was comfortable, clean and safe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The time spent in all areas was acceptable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You were given prompt attention by the Staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You were treated Courteously by all Staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Staff kept you informed of what was happening "next".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your physician(s) adequately explained the procedure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How do you rank the Overall Quality of Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My privacy was maintained through-out my stay.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you recommend Lowry Surgery Center to your friends or family? Yes No

How many times have you been a patient at Lowry? _____

COMMENTS _____

Signature (optional) _____