Emergency Department Care Feedback Form

Date of Visit

MM/DD/YYYY

Reason for Visit (optional)

e.g. injury, illness, etc.

How would you rate your overall care?

○ **Excellent** ○ **Good** ○ **Fair** ○ **Poor**

Staff professionalism

○ **Excellent** ○ **Good** ○ **Fair** ○ **Poor**

Timeliness of care

○ **Excellent** ○ **Good** ○ **Fair** ○ **Poor**

Were your questions and concerns addressed?

○ **Yes** ○ **No**

How can we improve your experience?

Your feedback

Would you like to be contacted?

○ **Yes** ○ **No**

If yes, your email

name@example.com