

Follow-Up Care Quality Feedback Sheet

Patient Information

Patient Name

Date of Feedback

Date of Follow-up Visit

Provider Name

Feedback

1. How would you rate the care you received during your follow-up visit?

☐

Excellent

☐

Good

☐

Average

☐

Poor

2. Did the provider listen carefully to you?

3. Did you receive care in a timely manner?

4. Was information provided to you in a way you could understand?

5. Would you recommend our follow-up care to others?

Comments

Additional comments or suggestions:

