Patient Experience Survey

General Information

Date of Visit

MM/DD/YYYY

Department Visited

e.g. Cardiology

About Your Experience

How would you rate your overall experience?

- 1
- 2
- 3
- 4
- 5

Were the healthcare staff courteous and helpful?

- Yes
- No

Did you feel your concerns were listened to?

- Yes
- No

How would you rate the clarity of information provided to you?

- Poor
- Fair
- Good
- Excellent

Facility

How clean was the facility?

- Poor
- Fair
- Good
- Excellent

How long did you wait before being seen?

Select

Additional Comments

Please tell us about anything we could do to improve your experience.

Your comments