

## THE CENTER FOR CANCER AND HEMATOLOGIC DISEASE

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Our goal is to provide the very best medical care to all our patients. We'd like to know how you feel about our medical facility, physicians and staff members. Thank you for your help.

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### PLEASE RATE THE FOLLOWING:

#### A. YOUR APPOINTMENT:

	excellent	very good	good	fair	poor	N/A*
1. Making your appointment by telephone	5	4	3	2	1	N/A
2. Efficiency of the registration process	5	4	3	2	1	N/A
3. Waiting time in reception area	5	4	3	2	1	N/A
4. Waiting time in exam room	5	4	3	2	1	N/A

#### B. OUR STAFF

##### FRONT OFFICE

1. Courtesy and professionalism of staff	5	4	3	2	1	N/A
2. Concerns were addressed	5	4	3	2	1	N/A
3. Appointments made correctly	5	4	3	2	1	N/A

##### LABORATORY

1. Courtesy and professionalism of staff	5	4	3	2	1	N/A
2. Concerns were addressed	5	4	3	2	1	N/A
3. Ease of obtaining blood	5	4	3	2	1	N/A

##### NURSING

1. Courtesy and professionalism of nursing staff	5	4	3	2	1	N/A
2. Concerns were addressed	5	4	3	2	1	N/

#### C. OUR COMMUNICATION WITH YOU

1. Phone calls picked up promptly by receptionist	5	4	3	2	1	N/A
2. Information provided about financial arrangements, insurance claims, etc.	5	4	3	2	1	N/A
3. You received adequate health information reading material	5	4	3	2	1	N/A
4. Nurse/Doctor returning your calls in a timely manner	5	4	3	2	1	N/A

**D. YOUR VISIT WITH THE DOCTOR**

1. The doctor took a personal interest in you and your problem	5	4	3	2	1	N/A
2. Questions answered fully	5	4	3	2	1	N/A
3. The doctor's respect for your privacy	5	4	3	2	1	N/A
4. Adequately explaining treatment options and procedures	5	4	3	2	1	N/A
5. Instructions regarding medical and follow-up care	5	4	3	2	1	N/A

Please provide the name of the doctor you saw \_\_\_\_\_

(Please remember that you do not need to provide your name if you do not wish to.)

**E. OUR FACILITY**

1. Was your appointment at a convenient time	5	4	3	2	1	N/A
2. Your comfort in reception area/exam room	5	4	3	2	1	N/A
3. Your comfort in the chemotherapy suite	5	4	3	2	1	N/A

**F. YOUR OVERALL SATISFACTION**

1. Our practice	5	4	3	2	1	N/A
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WOULD YOU RECOMMEND OUR PRACTICE TO A FAMILY MEMBER? YES NO

IF NO, PLEASE TELL US WHY: \_\_\_\_\_

IF THERE IS ONE THING YOU PARTICULARLY LIKE ABOUT OUR PRACTICE, PLEASE TELL US \_\_\_\_\_

IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT \_\_\_\_\_

ARE YOU A: NEW PATIENT RETURNING PATIENT

NAME (OPTIONAL) \_\_\_\_\_

APPOINTMENT DATE \_\_\_\_\_