

Outpatient Survey

*Please drop completed survey in suggestion box in waiting area,
or give to admitting in sealed envelope provided when exiting the facility*



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www.mvhealth.org

509.826.1760

Thank you for completing this questionnaire. We use your feedback to improve our services.

Background Questions (write in answer or fill in square as appropriate)

1. Patient's first visit here? Yes No
2. Date of visit / /
month day year

Please check which of the following procedures you were here for:

- Laboratory Respiratory therapy Obstetrics
 X-ray/ultrasound Outpatient surgery Pain clinic
 Physical therapy Emergency room Other

A. Admission

	Very Poor	Poor	Fair	Good	Very Good
1. Verification of personal information and insurance	1	2	3	4	5
2. Courtesy of the admitting person	1	2	3	4	5
3. Admitters ability to assist you with questions or directions (if any)	1	2	3	4	5
4. Rating of pre-admission process (if any)	1	2	3	4	5

Comments: _____

B. Tests and Treatments

	Very Poor	Poor	Fair	Good	Very Good
1. Waiting time for tests or treatments	1	2	3	4	5
2. Concern shown for your comfort during tests or treatments	1	2	3	4	5
3. Courtesy of the person did your blood draw (if applicable)	1	2	3	4	5
4. Courtesy of the person who started the IV (if applicable)	1	2	3	4	5

Comments: _____

C. Accomodations

	Very Poor	Poor	Fair	Good	Very Good
1. Cleanliness	1	2	3	4	5
2. General atmosphere	1	2	3	4	5

Comments: _____

D. Personal issues

	Very Poor	Poor	Fair	Good	Very Good
1. Staff concern for your privacy	1	2	3	4	5
2. Degree to which hospital staff addressed your emotional needs	1	2	3	4	5
3. Response to concerns/complaints made during your visit	1	2	3	4	5

Comments: _____

E. Overall assessment

	Very Poor	Poor	Fair	Good	Very Good
1. Overall cheerfulness of the hospital	1	2	3	4	5
2. How well staff worked together to care for you	1	2	3	4	5
3. Likelihood of your recommending this hospital to others	1	2	3	4	5
4. Overall rating of care given at hospital	1	2	3	4	5

Comments: _____

Patients name: (optional) _____

Telephone Number: (optional) _____

Address: (optional) _____

