

## Patient Satisfaction Survey

Dear Patient:

It is our goal at Osler Medical to provide you with quality medical services in a courteous, efficient, and professional atmosphere. To assist us in our goal, we ask for your opinion. Please take a few minutes to complete this questionnaire so we will know how we have served you and where we might improve.

This survey is specifically related to your visit with Osler physician \_\_\_\_\_  
*(specify Physician you are rating)* within the last 60 days. Any other feedback you can provide us is also welcome.

	Excellent	Very Good	Good	Fair	Poor
<b>A. Your Appointment</b>					
1. Ease of getting through to the office by phone	5	4	3	2	1
2. Appointments available within 2 weeks for non-urgent care and 2 days for illnesses	5	4	3	2	1
3. Waiting time in the reception area	5	4	3	2	1
4. Waiting time in the exam room	5	4	3	2	1
<b>B. Our Staff</b>					
1. The courtesy of the person who took your call	5	4	3	2	1
2. The friendliness and courtesy of the receptionist(s)	5	4	3	2	1
3. The professionalism of our clinical staff	5	4	3	2	1
4. The helpfulness of the people in our business office	5	4	3	2	1
<b>C. Your Visit with the Doctor</b>					
1. The doctor listening to you	5	4	3	2	1
2. The doctor answering your questions	5	4	3	2	1
3. Amount of time the doctor spent with you	5	4	3	2	1
4. The doctor adequately explaining treatment options	5	4	3	2	1
5. The doctor's instructions regarding follow-up care	5	4	3	2	1
6. The thoroughness of the examination	5	4	3	2	1
7. The trust you have in your doctor to put your medical needs above all other considerations, including cost	5	4	3	2	1
8. Your belief that this doctor is well-qualified to manage medical problems like yours	5	4	3	2	1
9. The confidence you have that your doctor will always act to provide you with the best medical care possible	5	4	3	2	1

**D. Our Facility**

1. Hours of operation convenient for you	5	4	3	2	1
2. Overall comfort	5	4	3	2	1
3. Adequate parking	5	4	3	2	1
4. Signage and directions easy to follow	5	4	3	2	1

**E. YOUR OVERALL SATISFACTION WITH:**

1. Our practice	5	4	3	2	1
2. The quality of your medical care you received	5	4	3	2	1

**WOULD YOU RECOMMEND THIS DOCTOR TO OTHERS?**       Yes       No

**WOULD YOU RECOMMEND OSLER MEDICAL TO A FRIEND?**       Yes       No

If no to either of the above questions, please tell us why?

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Would you be opposed to Osler Medical utilizing e-mail addresses to notify our patients of recent medical advancements, new services offered, introduction of physicians, schedule changes, etc?

Yes       No      E-Mail Address: \_\_\_\_\_

**What can we do to improve our services to you?**

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*(If more comments are needed – please use additional paper)*

**We appreciate the time you have given in completing this form. The information will be useful to us in our continuing efforts to improve the quality of medical services.**

***Thank you very much for your help!***