Satisfaction Survey

In order that I may serve my patients better, please fill out the following survey and return to the address shown at the top right of this form. All responses are private. If you wish, you may include your name, address and phone number in the spaces provided below.

Please check which of the following services I provided to you:

❐ Wound Care ❐ Ostomy Care ❐ Continence Care ❐ Foot Care

Please check which patient type best describes you:

❐ Patient ❐ Family Member ❐ Caregiver

On a scale of 1 to 5, with 1 being the lowest and 5 being the highest, please evaluate my performance on the following. Please circle the appropriate number.

	(Lowest)				(Highest)	
Responds to my requests quickly	1	2	3	4	5	N/A
Respectful towards myself and my family	1	2	3	4	5	N/A
Able to meet my needs	1	2	3	4	5	N/A
Helped solve my problems	1	2	3	4	5	N/A
Explained my care clearly	1	2	3	4	5	N/A
Helped me learn to use the products	1	2	3	4	5	N/A
Taught me how to take care of myself	1	2	3	4	5	N/A
Cared about me	1	2	3	4	5	N/A
Overall performance rating	1	2	3	4	5	N/A

Briefly describe a situation that reflects the impact of having ______________________ participate in your medical care.

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Name (optional) Address (optional)

Thank you for your participation. Your input is very valuable.