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 customer type best describes you:

❒ Physician ❒ Nurse ❒ Insurance Company ❒ DMERC ❒ Other_____
(specify)

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)	
Knowledgeable	1	2	3	4	5	N/A
Assess needs appropriately	1	2	3	4	5	N/A
Performs patient care appropriately	1	2	3	4	5	N/A
Maintains caring attitude toward patients	1	2	3	4	5	N/A
Innovative problem solver	1	2	3	4	5	N/A
Professional	1	2	3	4	5	N/A
Communicates well	1	2	3	4	5	N/A
Responds in a timely manner	1	2	3	4	5	N/A
Completes documents accurately	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 patient medical care.

_____

_____

_____

_____ _____

Name (optional) Address (optional)