PATIENT SATISFACTION SURVEY

DATE OF VISIT ______________________________

THANK YOU FOR TAKING A MOMENT TO COMPLETE THIS SURVEY. YOUR OPINION IS IMPORTANT TO US.

PLEASE CHECK THE SERVICE YOU RECEIVED:
O GASTROINTESTINAL O ORTHOPEDICS O GYNECOLOGY O UROLOGY
O REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY O PAIN MANAGEMENT O PODIATRY
O GENERAL SURGERY O COLORECTAL SURGERY O __________________________

WAS THIS YOUR FIRST VISIT TO OUR AMBULATORY SURGERY CENTER? O YES O NO

PLEASE RATE THE AMBULATORY SURGERY SERVICES YOU RECEIVED AT BROOKLYN SURGERY CENTER BY SELECTING THE RESPONSE THAT BEST DESCRIBES YOUR EXPERIENE. IF A QUESTION DOEES NOT APPLY, PLEASE SKIP TO THE NEXT QUESTION.

	EXCELLENT	GOOD	POOR
1. EASE OF ACCESS TO THE FACILITY	O	O	O
2. TIMELINESS OF ADMITTING PROCESS	O	O	O
3. FRIENDLINESS, COURTESY & HELPFULNESS OF THE RECEPTIONIST	O	O	O
4. COMFORT AND ATTRACTIVENESS OF THE FACILITY	O	O	O
5. CLEANLINESS OF THE FACILITY	O	O	O
6. WAITING TIME BEFORE YOUR PROCEDURE OR SURGERY BEGAN	O	O	O
7. FRIENDLINESS AND COURTESY OF THE NURSING STAFF	O	O	O
8. OVERALL QUALITY OF CARE PROVIDED BY YOUR PHYSICIAN/SURGEON	O	O	O
9. OVERALL QUALITY OF CARE PROVIDED BY THE ANESTHESIOLOGIST	O	O	O
10. OUR CONCERN FOR YOUR PRIVACY	O	O	O
11. OVERALL RATING OF THE CARE YOU RECEIVED	O	O	O
12. LIKELIHOOD OF YOU RECOMMENDING OUR CENTER TO OTHERS	O	O	O

WHAT DO YOU LIKE BEST ABOUT OUR CENTER? ______________________________

WHAT DO YOU LIKE LEAST ABOUT OUR CENTER? ______________________________

HOW COULD WE IMPROVE OUR SERVICE? ______________________________

YOUR PHYSICIAN'S NAME (OPTIONAL) ______________________________

YOUR NAME (OPTIONAL) ______________________________

THANK YOU FOR COMPLETING OUR SURVEY

TO COMPLETE THIS SURVEY ONLINE, VISIT OUR WEBSITE
WWW.BROOKLYNSURGERYCENTER.COM
AND CLICK ON PATIENT SURVEY