



PATIENT SATISFACTION SURVEY

We are striving to provide you with the best possible care. Please help us to achieve this goal by taking a few minutes of your time to answer the following questions. In doing so you will help us to provide optimum care for all our patients.

Name: (optional) _____ Date: _____

Type of examination: _____

Was it easy to schedule your appointment for today's test? Yes No

If no, explain why? _____

Was your scheduler: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Was your examination started on time? Yes No

If not, how long did you wait for your examination:

- Less than 15 minutes
- 15 – 30 minutes
- 30 minutes or more

If more than 15 minutes, did someone explain the reason for delay? Yes No

Was your receptionist: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Was the technologist who performed the procedure: *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

If your exam required a Radiologist (Doctor): *(Check all that apply.)*

- Courteous? Yes No
- Attentive to your needs? Yes No
- Efficient? Yes No

Please rate your overall experience. *(Circle a number on the scale below to indicate your level of satisfaction)*

1 2
⏟
Poor

3 4
⏟
Fair

5 6
⏟
Satisfied

7 8
⏟
Very Satisfied

9 10
⏟
Excellent

Any additional comments that you can make would be helpful: *(The use of names would be helpful.)*

Thank you for taking the time to complete this survey.