

PATIENT SATISFACTION SURVEY

HEALTHWISE DIAGNOSTICS

TO ASSIST US IN MONITORING THE QUALITY OF OUR SERVICE, PLEASE TAKE A FEW MINUTES TO COMPLETE THIS QUESTIONNAIRE.

TEST PERFORMED: _____

DATE: _____

1. WAS THE CLINIC EASY TO FIND? YES() NO()
2. DID THE RECEPTIONIST ATTEND TO YOU PROMPTLY AND COURTEOUSLY UPON ARRIVAL IN THE CLINIC? YES() NO()
3. WERE YOU TAKEN TO THE EXAMINATION ROOM ON TIME? YES() NO()
4. WAS THE TEST EXPLAINED TO YOU BEFORE IT WAS STARTED? YES() NO()
5. WERE YOUR QUESTIONS ANSWERED SATISFACTORILY? YES() NO()
6. DID YOU FEEL YOU HAD ENOUGH PRIVACY? YES() NO()
7. DID YOU FIND THE ATMOSPHERE OF THE CLINIC PLEASANT? YES() NO()
8. WOULD YOU RETURN TO THIS CLINIC FOR TESTING AGAIN? YES() NO()
9. IF YOU HAD A STRESS TEST, WAS THE SUPERVISING PHYSICIAN ATTENTIVE? YES() NO() N/A()

GENERAL COMMENTS AND/OR SUGGESTIONS:

THANK YOU KINDLY FOR YOUR COOPERATION AND INPUT.