

1. How long does it take to travel here?
 Less than 10 minutes
 10-20 minutes
 21-30 minutes
 Over 30 minutes

2. When you call the office, does the receptionist answer your calls courteously and promptly?
 All of the Time
 Some of the Time
 None of the Time

3. Did the Staff treat you courteously?

	All the time	Some of the Time	None of the Time
Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secretaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. On average, how many minutes did you have to wait past your scheduled appointment time?
 For Treatment _____ minutes
 For weekly status check _____ minutes
 For Follow-up visit _____ minutes

5. Did you feel we gave you enough information and explained the procedures satisfactorily?:

	All the time	Some of the Time	None of the Time
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simulation/ Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Did you receive referrals for additional services listed below while on treatment?
 Yes No

*If yes, check which services:
 Social Worker

Dietitian
 Spiritual/Clergy
 Support Groups

7. What additional services would you like provided?

8. Was the insurance advisor helpful in explaining your responsibilities and financial obligations?

	All the time	Some of the Time	None of the Time
Helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Courteous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Did you feel that your physician answered all your questions to your satisfaction?
 Yes
 Somewhat
 No

10. During the weeks of treatment did you experience any side effects?
 Yes No

11. If yes, do you feel that the staff provided adequate assistance to help you with these side-effects?
 Yes No

12. During the weeks of treatment did you experience any pain?
 Yes No

13. If yes, do you feel that the staff provided adequate assistance for pain relief?
 Yes No

14. Upon completion, was follow-up planning arranged for your care?

Yes

No

Please provide any additional confidential comments:

Thank you for your time and assistance.

Name(optional) _____ Date _____

Dear Patient,

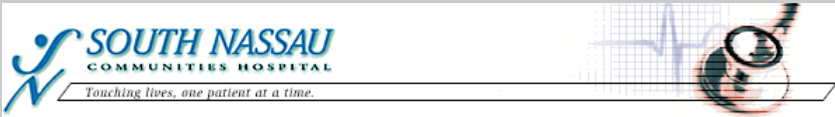
Please help us learn what we can do to improve upon our services by answering the questions and statements below.

You have the option of completing this questionnaire anonymously if you wish. Whether or not you sign your name, the information you provide will be kept confidential and in no way be linked to your medical record or any future medical care you may receive.

Your assistance is greatly appreciated.

Edward Mullen, MD

Louis Potters, M.D.



Patient Satisfaction Survey Department of Radiation Oncology