North Shore LIJ Medical Group

Formed Approved
OMB No. 0920-0953
Exp. Date 12/31/2015

MEDICAL PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

Please rate your visit on/with:

BACKGROUND QUESTIONS

1. If someone other than the patient is completing this survey, please fill in circle: ○
2. Was this your first visit here?.... ○ Yes ○ No
3. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room?..... ☐☐☐ minutes
4. How many **minutes** did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife?..... ☐☐☐ minutes

---

INSTRUCTIONS: Please rate the medical practice services you received from the North Shore LIJ Health System. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of getting through to the practice on the phone	○	○	○	○	○
2. Convenience of our office hours	○	○	○	○	○
3. Ease of scheduling your appointment	○	○	○	○	○
4. Courtesy of staff in the registration area	○	○	○	○	○

Comments (describe good or bad experience): _____

MOVING THROUGH YOUR VISIT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. If you experienced delays, degree to which you were informed about these delays	○	○	○	○	○
2. Wait time at practice (from scheduled appointment time to leaving)	○	○	○	○	○

Comments (describe good or bad experience): _____

NURSE/ASSISTANT/TECHNICIAN/NON-MD STAFF

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Friendliness/courtesy of the staff	○	○	○	○	○
2. Concern the staff showed for your problem	○	○	○	○	○

Comments (describe good or bad experience): _____

continued...

Draft

CARE PROVIDER

	very poor 1	poor 2	fair 3	good 4	very good 5

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE.
PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.
Complete this section only if your visit was to be seen by your care provider, otherwise leave this section blank.

1.	Friendliness/courtesy of the care provider	O	O	O	O	O
2.	Explanations the care provider gave you about your problem or condition	O	O	O	O	O
3.	Concern the care provider showed for your questions or worries	O	O	O	O	O
4.	Care provider's efforts to include you in decisions about your treatment	O	O	O	O	O
5.	Information the care provider gave you about medications (if any)	O	O	O	O	O
6.	Instructions the care provider gave you about follow-up care (if any)	O	O	O	O	O
7.	Degree to which care provider talked with you using words you could understand	O	O	O	O	O
8.	Amount of time the care provider spent with you	O	O	O	O	O
9.	Your confidence in this care provider	O	O	O	O	O
10.	Likelihood of your recommending this care provider to others	O	O	O	O	O

Comments (describe good or bad experience): _____

PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5

1.	How well staff protected your safety (by washing hands, wearing gloves, etc.)	O	O	O	O	O
2.	Our sensitivity to your needs	O	O	O	O	O
3.	Our concern for your privacy	O	O	O	O	O
4.	Cleanliness of our practice	O	O	O	O	O

Comments (describe good or bad experience): _____

ELECTRONIC MEDICAL RECORD

	very poor 1	poor 2	fair 3	good 4	very good 5

1.	Degree to which having an electronic medical record system (computer) in the room makes your interactions with the provider easier	O	O	O	O	O
2.	Effect of electronic medical record system on the length of your visit	O	O	O	O	O
3.	Degree to which your care is improved because of the electronic medical record	O	O	O	O	O

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5

1.	How well the staff worked together to care for you	O	O	O	O	O
2.	Likelihood of your recommending our practice to others	O	O	O	O	O

Comments (describe good or bad experience): _____

Patient's Name: *(optional)* _____

Telephone Number: *(optional)* _____

PRESS GANEY™

Draft