

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: O
- 2. Was this your first visit here?.... O Yes O No
- 3. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room?......
- 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?....



INSTRUCTIONS: Please rate the medical practice services you received from the North Shore LIJ Health System. <u>Select the response</u> 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:

		very				very
AC	CESS	poor 1	poor 2	fair 3	good 4	good 5
1.	Ease of getting through to the practice on the phone					
2.	Convenience of our office hours	. 0	0	0	0	0
3.	Ease of scheduling your appointment	. 0	0	0	0	0
4.	Courtesy of staff in the registration area	. O	0	0	0	0

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.	0	0	0	0	0
2. Wait time at practice (from scheduled appointment time to leaving)	0	0	0	0	0

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	0	0	0	0	0	
2. Concern the staff showed for your problem	O	0	0	0	0	
Comments (describe good or bad experience):						

Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to - CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333 ATTN: PRA (0920-0953).





		very				very
	DE DDAVIDED	poor	poor	fair	good	good
CA	ARE PROVIDER	1	2	3	4	5
ASSI PLE/	ING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN STANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. ASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN	MINE	-			
Com	plete this section only if your visit was to be seen by your care provider, other	wise				
leave	e this section blank.					
1.	Friendliness/courtesy of the care provider	. O	0	0	0	0
2.	Explanations the care provider gave you about your problem or condition	. 0	0	0	0	0
3.	Concern the care provider showed for your questions or worries	. O	0	0	0	0
4.	Care provider's efforts to include you in decisions about your treatment	. O	0	0	0	0
5.	Information the care provider gave you about medications (if any)	. O	0	0	0	0
6.	Instructions the care provider gave you about follow-up care (if any)	. O	0	0	0	0
7.	Degree to which care provider talked with you using words you could understand	. O	0	0	0	0
8.	Amount of time the care provider spent with you	. O	0	0	0	0
9.	Your confidence in this care provider	. O	0	0	0	0
10.	Likelihood of your recommending this care provider to others	. 0	0	0	0	0

Comments (describe good or bad experience):

PERSONAL ISSUESpoor 1poor 2fair 3good 4good 51. How well staff protected your safety (by washing hands, wearing gloves, etc.)000002. Our sensitivity to your needs000000003. Our concern for your privacy0000000004. Cleanliness of our practice000000000			very				very
1. How well staff protected your safety (by washing hands, wearing gloves, etc.)00002. Our sensitivity to your needs000003. Our concern for your privacy00000	PE	RSONAL ISSUES	poor 1	poor 2	fair 3	good 4	good 5
3. Our concern for your privacy O O O O O	1.						
	2.	Our sensitivity to your needs	. 0	0	0	0	0
4. Cleanliness of our practice	3.	Our concern for your privacy	0	0	0	0	0
	4.	Cleanliness of our practice	O	0	0	0	0

Comments (describe good or bad experience):___

		very				very
EL	ECTRONIC MEDICAL RECORD	poor 1	poor 2	fair 3	good 4	good 5
1.	Degree to which having an electronic medical record system (computer) in the room makes your interactions with the provider easier	. 0	0	0	0	0
2.	Effect of electronic medical record system on the length of your visit	. O	0	0	0	0
3.	Degree to which your care is improved because of the electronic medical record	. 0	0	0	0	0

Comments (describe good or bad experience):____

OVERALL ASSESSMENT	very poor 1	poor 2	fair 3		very good 5		
1. How well the staff worked together to care for you	0	0	0	0	0		
2. Likelihood of your recommending our practice to others	O	0	0	0	0		
Comments (describe good or bad experience):							

Patient's Name: (optional)

Telephone Number: (optional)_____

© 2004 PRESS GANEY ASSOCIATES, INC., All Rights Reserved CL#12062-MD0104-02-06/11



