

# 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

- |   |  |
|---|--|
| <p>1. If someone other than the patient is completing this survey, please fill in circle: <input type="radio"/></p> <p>2. Was this your first visit here?.... <input type="radio"/> Yes <input type="radio"/> No</p> <p>3. How many <b>minutes</b> did you wait after your scheduled appointment time before you were called to an exam room?..... <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/><br/>minutes</p> | <p>4. How many <b>minutes</b> did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife?..... <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/><br/>minutes</p> |
|---|--|

**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: ●

<b>ACCESS</b>	very poor <b>1</b>	poor <b>2</b>	fair <b>3</b>	good <b>4</b>	very good <b>5</b>
1. Ease of getting through to the practice on the phone .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Convenience of our office hours .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Ease of scheduling your appointment .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Courtesy of staff in the registration area .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments** (describe good or bad experience): \_\_\_\_\_  
\_\_\_\_\_

<b>MOVING THROUGH YOUR VISIT</b>	very poor <b>1</b>	poor <b>2</b>	fair <b>3</b>	good <b>4</b>	very good <b>5</b>
1. If you experienced delays, degree to which you were informed about these delays ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Wait time at practice (from scheduled appointment time to leaving).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments** (describe good or bad experience): \_\_\_\_\_  
\_\_\_\_\_

<b>NURSE/ASSISTANT/TECHNICIAN/NON-MD STAFF</b>	very poor <b>1</b>	poor <b>2</b>	fair <b>3</b>	good <b>4</b>	very good <b>5</b>
1. Friendliness/courtesy of the staff.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Concern the staff showed for your problem.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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).

continued...



## CARE PROVIDER

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

**Comments** (describe good or bad experience): \_\_\_\_\_

## PERSONAL ISSUES

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

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well staff protected your safety (by washing hands, wearing gloves, etc.)..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Our sensitivity to your needs .....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Our concern for your privacy.....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Cleanliness of our practice.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**Comments** (describe good or bad experience): \_\_\_\_\_

## ELECTRONIC MEDICAL RECORD

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

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Degree to which having an electronic medical record system (computer) in the room makes your interactions with the provider easier..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Effect of electronic medical record system on the length of your visit.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Degree to which your care is improved because of the electronic medical record .....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**Comments** (describe good or bad experience): \_\_\_\_\_

## OVERALL ASSESSMENT

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

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the staff worked together to care for you.....      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Likelihood of your recommending our practice to others ..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**Comments** (describe good or bad experience): \_\_\_\_\_

Patient's Name: *(optional)* \_\_\_\_\_

Telephone Number: *(optional)* \_\_\_\_\_

