Patient Experience Care Survey

OMB 2900-0770
Estimated burden: 5 minutes
Expiration Date xx/xx/xxxx

The Paperwork Reduction Act of 1995: This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average five (5) minutes. This includes the time it will take to follow instructions, gather the necessary facts and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this telephone/mail survey will lead to improvements in the quality of service delivery by helping to achieve services. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

[Hospital / Emergency Department Name]

Patient Experience of Care Survey

This Patient Experience of Care Survey is to help the doctor understand your experience in the emergency department on your *last* visit. Thank you for taking the time to complete this survey.

Doctor name (if you remember it): _____

Date of the visit to the emergency department: _____

Mark the circle that best describes your experience.

1. Did this doctor listen carefully to you?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

2. Did this doctor explain things in a way that was easy to understand?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

3. Did this doctor tell you what your medical problem was?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

4. Did this doctor tell you the results of any medical tests or x-rays?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No ❍ I had no tests done

5. Did this doctor tell you how to improve your medical condition?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

6. Did this doctor ask about your preferences for treatment choices?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No ❍ Not applicable

7. Did this doctor ask about your known medical conditions, medications, or allergies?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

8. Did this doctor spend enough time with you?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

9. Did this doctor show you respect and treat you with dignity?
   ❍ Yes, definitely ❍ Yes, somewhat ❍ No

10. Did this doctor ask if you had any questions?
    ❍ Yes, definitely ❍ Yes, somewhat ❍ No

11. Did this doctor ask you about your pain?
    ❍ Yes, definitely ❍ Yes, somewhat ❍ No ❍ Not applicable

12. Please provide any additional comments that you would like us to know.