

Thank you for your participation in the WTC Health Program at NYUSOM Clinical Center of Excellence!

We would like your help in improving our CCE and being able to better serve our patients. Please help us by taking a few minutes to tell us about your treatment visit. This survey is anonymous. We appreciate your insights and feedback.

Question:

When was your monitoring exam?

Month: _____ Year: _____

Question:

Which treatment provider(s) did you visit? Please check all that apply

- | | |
|-------------------------------------|------------------------------------|
| <input type="radio"/> Pulmonary | <input type="radio"/> Social Work |
| <input type="radio"/> ENT | <input type="radio"/> Neurology |
| <input type="radio"/> GI | <input type="radio"/> Cardiology |
| <input type="radio"/> Mental Health | <input type="radio"/> Other: _____ |

Question:

What was the reason for your visit? Please check all that apply

- | | |
|--|---|
| <input type="radio"/> Physical health concerns | <input type="radio"/> Medication needs |
| <input type="radio"/> Mental health concerns | <input type="radio"/> Workers Compensation |
| <input type="radio"/> Social Services needs | <input type="radio"/> Victims Compensation Fund |
| <input type="radio"/> Asked by family member | <input type="radio"/> Other: _____ |
| <input type="radio"/> Centralizing your healthcare | |

Question:

Please indicate why the NYU CCE was the best option for your care

Question:

Were you referred to other specialty for further follow-up?

Yes No

Question:

Did you accept your treatment referral?

Yes No

Question:

Will you continue to participate in the treatment program?

Yes No (Please tell us why)



Please rate each component of your treatment experience by placing a circle around the appropriate reaction:

☹️ - Very Dissatisfied

😞 - Dissatisfied

😐 - Somewhat Dissatisfied

😌 - Neutral

😊 - Somewhat Satisfied

😄 - Satisfied

😁 - Very Satisfied

N/A - Not Applicable

Staff Friendliness

☹️ 😞 😐 😌 😄 😁 N/A

Social Work

☹️ 😞 😐 😌 😄 😁 N/A

Relaying of Examination Results

☹️ 😞 😐 😌 😄 😁 N/A

Timeliness

☹️ 😞 😐 😌 😄 😁 N/A

Group Therapy

☹️ 😞 😐 😌 😄 😁 N/A

Making Appointments

☹️ 😞 😐 😌 😄 😁 N/A

Medical Doctor

☹️ 😞 😐 😌 😄 😁 N/A

Medications

☹️ 😞 😐 😌 😄 😁 N/A

Overall Experience

☹️ 😞 😐 😌 😄 😁 N/A

Mental Health Provider

☹️ 😞 😐 😌 😄 😁 N/A

Tests/Procedures

☹️ 😞 😐 😌 😄 😁 N/A

Question:

If you selected that you were 'Somewhat Dissatisfied', 'Dissatisfied' or 'Very Dissatisfied' with one or more component of your examination, please tell us why:

Question:

Is there anything you would like for us to improve on?

Thank you for your feedback! We value you as a member and will take your input into consideration while continuing to provide you with care and services in the future. You may contact our office, Monday – Friday, between 9am – 5pm, at (212) 263-7335 if you have any questions regarding your care.

Public reporting burden of this collection of information is estimated to average 2 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).