World Trade Center Health Program
Clinical Center of Excellence

Patient Label

Form Approved
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Telehealth Services Patient Satisfaction Questionnaire

Date: _____

We want to know what you thought about today's telehealth session. Your honest answers will help us improve the system. Please circle the number that is closest to your own opinion for each of the following statements.

	STRONGLY DISAGREE		DO NOT AGREE		STRONGLY AGREE
Example: *I felt well when I woke up this morning.*	*1*	*2*	*3*	*4*	*5*
I felt comfortable with the equipment used.	1	2	3	4	5
I was able to see the clinician clearly.	1	2	3	4	5
I was able to hear the clinician clearly.	1	2	3	4	5
There was enough technical assistance for my meeting with the clinician.	1	2	3	4	5
My relationship with the clinician was the same during this session as it is in person.	1	2	3	4	5
The location of the telehealth clinic is convenient for me. N / A	1	2	3	4	5
My needs were met during the session.	1	2	3	4	5
I received good care during the session.	1	2	3	4	5
Overall, I am satisfied with this telehealth session.	1	2	3	4	5
I would recommend this type of session to others.	1	2	3	4	5
I would rather use telehealth to receive this service than travel to see my clinician.	1	2	3	4	5

Did you have in-person options for today's session?

- ☐ Yes
- ☐ No

What was the location of your session today?

- ☐ WTC Program Clinic
- ☐ Private Home
- ☐ Other

If you had other options for the session, why did you choose telehealth? (select all that apply)

- ☐ Reduced travel time
- ☐ Reduced travel cost
- ☐ Availability of specialized clinician or treatment
- ☐ Availability of a clinician who could see me more frequently
- ☐ Availability of a clinician who could see me more quickly

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☐ Other_____