Outpatient Services

National Institutes of Health
Clinical Center

OUTPATIENT SERVICES SURVEY

INSTRUCTIONS: Please rate the outpatient service you received from our facility. 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.

If you can't complete the entire survey at once, you may come back to it later. Your previous responses will be saved automatically and you will be able to continue where you left off. At any point during the survey, you can clear the entire survey and start over by clicking the "Clear Survey" button.

When you have finished, please click the "Submit" button.

Progress 0% 100%

THE SERVICE YOU RECEIVED (SELECT ONE RESPONSE ONLY)

1) **Please select the last outpatient test or treatment you received. Rate only that service and visit.**

- ○ Radiation Oncology (B2)
- ○ Dowling Clinic (Apheresis)

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Progress 0% 100%

REGISTRATION

	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
1) Helpfulness of the person at the registration desk	○	○	○	○	○
2) Ease of the registration process	○	○	○	○	○
3) Waiting time in registration	○	○	○	○	○
4) Comfort of the waiting area	○	○	○	○	○

5) **Comments** (describe good or bad experience):

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YOUR CARE	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
1) Staff's explanation of the test or treatment	○	○	○	○	○
2) Staff provided opportunity to ask questions	○	○	○	○	○
3) Your trust in the skill of the staff who provided your test or treatment	○	○	○	○	○
4) Staff's concern for your comfort	○	○	○	○	○
5) Staff treated you with respect and dignity	○	○	○	○	○
6) Response to concerns/complaints made during your visit	○	○	○	○	○
7) Our sensitivity to your needs	○	○	○	○	○

8) **Comments** (describe good or bad experience):

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0% 100%

OVERALL ASSESSMENT	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
1) How well staff worked together to provide care	○	○	○	○	○
2) Likelihood of your recommending our facility to others	○	○	○	○	○

3) **Comments** (describe good or bad experience):

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1) Patient's Name: (optional)

2) Telephone Number: (optional)

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