



Dear Patient,

Our mission at the NIH Clinical Center is to provide our patients with the highest quality health care that we can. To accomplish this, we need to know what we are doing right and what needs improvement. We depend on our patients and their families to keep us informed.

By sharing your thoughts and feelings about your health care experience, you can help make our care better for future patients and their families. Please take a few minutes to complete the following patient experience survey. If you choose not to participate, this will not affect your care.

Thank you for your participation.

Sincerely,

A handwritten signature in black ink, appearing to read "James K. Gilman". The signature is fluid and cursive, with a large initial "J" and "G".

James K. Gilman, M.D.
Chief Executive Officer
NIH Clinical Center

INPATIENT SURVEY

OMB No. 0925-0648 Expiration Date: 05/2021

Public reporting burden for this collection of information is estimated to average 5 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: NIH Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0648). Do not return the completed form to this address.

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Date of admission:

		/			/				
month			day			year			

2. Date of discharge:

		/			/				
month			day			year			

3. Who is completing this survey? **(select one only)**

- Patient
- Friend
- Legal Guardian
- Spouse
- Family Member
- Other _____
(specify)

4. Location:

- 1SE
- 7SE

5. Protocol #

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INSTRUCTIONS: Please rate the services 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.

Please use black or blue ink to fill in the circle completely.
Example: ●

YOUR CARE	very poor	poor	fair	good	very good
	1	2	3	4	5
1. Staff's concern for your privacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How well the staff showed concern for your emotional needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Your feeling of safety on the unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Staff's efforts to include you in decisions about your care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Response to your concerns and complaints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

NURSES	very poor	poor	fair	good	very good
	1	2	3	4	5
1. Courtesy and respect of the nurses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Helpfulness of the nurses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Nurses' promptness in responding to your requests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____



continued...

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

YOUR CARE PROVIDERS ARE THE PEOPLE WHO ADDRESSED YOUR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CARE PROVIDERS MAY HAVE BEEN PSYCHIATRISTS, MEDICAL DOCTORS, PHYSICIAN ASSISTANTS (PAs), OR NURSE PRACTITIONERS (NPs). PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THESE HEALTH CARE PROVIDERS IN MIND.

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Courtesy and respect of the care providers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Helpfulness of time spent with the care providers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Information provided by the care providers about your condition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

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

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Helpfulness of group therapy sessions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Helpfulness of social/recreational activities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

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

- | | | | | | |
|------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Quality of the food | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|

Comments (describe good or bad experience): _____

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

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Understanding of your medication instructions at discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Information provided about your care after discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Instructions on what to do if you need help after discharge (when to seek help, whom to call, etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

	very poor	poor	fair	good	very good
OVERALL ASSESSMENT	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. Overall rating of care given at this facility | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Likelihood of your recommending this facility 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) _____

