



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? **(fill in one circle only)**

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

4. Location:

- 1SW

5. Protocol #

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INSTRUCTIONS: Please rate the services your child received from our facility. Select the response that best describes your child's experience. If a question does not apply, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to your child.

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

YOUR CHILD'S CARE

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

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YOUR CHILD'S CARE (...continued)	very poor	poor	fair	good	very good
1	2	3	4	5	5

6. Degree to which staff asked if your child had any physical pain

Comments (describe good or bad experience): _____

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

1. Courtesy and respect of the nurses
2. Helpfulness of the nurses
3. Nurses' promptness in responding to your child's requests

Comments (describe good or bad experience): _____

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

YOUR CHILD'S CARE PROVIDERS ARE THE PEOPLE WHO ADDRESSED THEIR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CHILD'S 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
2. Helpfulness of time your child spent with the care providers
3. Information provided by the care providers about your child's condition

Comments (describe good or bad experience): _____

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

1. Helpfulness of group therapy sessions
2. Helpfulness of social/recreational activities

Comments (describe good or bad experience): _____

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

1. Quality of the food

Comments (describe good or bad experience): _____

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

1. Understanding of your child's medication instructions at discharge
2. Information provided about your child's care after discharge
3. Instructions on what to do if your child needs help after discharge (when to seek help, whom to call, etc.)

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT	very poor	poor	fair	good	very good
1	2	3	4	5	5

1. How well the staff worked together to care for your child
2. Overall rating of care given at this facility
3. Likelihood of your recommending this facility to others

Comments (describe good or bad experience): _____

Patient's Name: (optional) _____

Parent or Guardian's Name: (optional) _____

Telephone Number: (optional) _____



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