



Public Health Nursing Customer Service Survey



Care- Giver

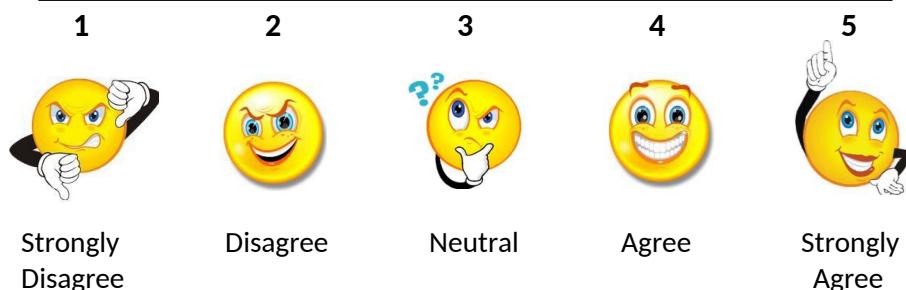
Patient's Community/Residence:

- | | | | | |
|---|---------------------------------------|---|---|--|
| <input type="checkbox"/> Black Mesa/Kitsillie | <input type="checkbox"/> Low Mountain | <input type="checkbox"/> Cottonwood/Blk Mtn | <input type="checkbox"/> Valley Store | <input type="checkbox"/> Round Rock |
| <input type="checkbox"/> Blue Gap/Tachee | <input type="checkbox"/> Pinon | <input type="checkbox"/> Canyon de Chelly | <input type="checkbox"/> Many Farms | <input type="checkbox"/> Lukachukai/U. Grswd |
| <input type="checkbox"/> Burntcorn | <input type="checkbox"/> Smoke Signal | <input type="checkbox"/> Spider Rock | <input type="checkbox"/> Salina Springs | <input type="checkbox"/> Tsale/Black Rock |
| <input type="checkbox"/> Forest Lake | <input type="checkbox"/> Whippoorwill | <input type="checkbox"/> Del Muerto | <input type="checkbox"/> Rough Rock | <input type="checkbox"/> Wheatfields |
| <input type="checkbox"/> Hard Rock | <input type="checkbox"/> Chinle | <input type="checkbox"/> Nazlini | <input type="checkbox"/> Rock Point | <input type="checkbox"/> Other _____ |

Patient's Gender: ___ Male ___ Female

Patient's Age: ___ 5 years and younger ___ 18 - 34 years ___ 65 years and older ___ 6 - 17 years ___ 35 - 64 years

For each statement below circle the number based on this scale:



- | | |
|---|-----------|
| 1. I would recommend Public Health Nursing (PHN) services to my family and friends | 1 2 3 4 5 |
| 2. I am sure I can take care of my patient's health | 1 2 3 4 5 |
| 3. I feel comfortable discussing my patient's care issues with PHN staff | 1 2 3 4 5 |
| 4. The PHN staff helped me make a plan to improve my patient's health | 1 2 3 4 5 |
| 5. I am able to get the care I need for my patient when I need it | 1 2 3 4 5 |
| 6. The PHN staff treated me and my patient with courtesy and respect at all times today | 1 2 3 4 5 |
| 7. The health information given to me by the PHN staff was explained clearly | 1 2 3 4 5 |
| 8. The PHN staff greeted me at the beginning of their visit | 1 2 3 4 5 |

What did we do well today? _____

How can we do better? _____

PHN STAFF USE ONLY

- | | | | | |
|---------------------------------------|--|-------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Group Visits | <input type="checkbox"/> Family Spirit | <input type="checkbox"/> Home Visit | <input type="checkbox"/> Flu Clinic | <input type="checkbox"/> Other _____ |
|---------------------------------------|--|-------------------------------------|-------------------------------------|--------------------------------------|

PHN Staff Name: _____

Date of Visit: _____

Revised

04.20.15

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0036. The time required to complete this information collection is estimated to average 3 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.