NIH National Institutes of Health
Clinical Center

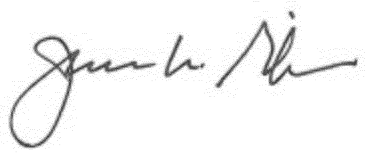
Dear Patient,

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,



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Chief Executive Officer
NIH Clinical Center

National Institutes of Health
Clinical Center

OUTPATIENT SURVEY

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

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 Visit

3. Protocol #

2. Location:
   ○ OP4

INSTRUCTIONS: Please rate the services your child received from our facility. <u>Select the response</u> that best describes your child's experience. If a question does not apply to your child, 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: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of getting an appointment	○	○	○	○	○
2. Convenience of available appointment times	○	○	○	○	○

Comments (describe good or bad experience):_____

CLINICAL AREA

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Cleanliness of the clinical area	○	○	○	○	○
2. Privacy of the clinical area	○	○	○	○	○
3. Comfort level in and around the clinical area	○	○	○	○	○

Comments (describe good or bad experience):_____

CARE PROVIDERS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy and respect of the care provider	○	○	○	○	○
2. Helpfulness of time your child spent with the care provider	○	○	○	○	○

YOUR CHILD'S CARE PROVIDER IS THE PERSON WHO ADDRESSES THEIR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CHILD'S CARE PROVIDER MAY BE A PSYCHIATRIST, MEDICAL DOCTOR, PHYSICIAN ASSISTANT (PA), OR NURSE PRACTITIONER (NP). <u>PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.</u>

this section continued on next page...

CARE PROVIDERS (...continued)

	very poor 1	poor 2	fair 3	good 4	very good 5
3. How well the care provider informed you and your child about your child's medication (if your child was prescribed medication)	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

THERAPIST(S)

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

If you did not see a Therapist during this visit, please skip this section. Thank you.

1. Your trust in the skill of the therapist(s)	○	○	○	○	○
2. Therapist's concern for your child's questions and worries	○	○	○	○	○
3. How well the therapist(s) understood your child and their needs	○	○	○	○	○
4. How well the therapist(s) kept you informed about your child's treatment	○	○	○	○	○

Therapist(s) Section Comments_____

_____

_____

YOUR CHILD'S CARE

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff's concern for your child's privacy	○	○	○	○	○
2. How well the staff addressed your child's emotional needs	○	○	○	○	○
3. Staff's response to concerns/complaints made during your child's care	○	○	○	○	○
4. Staff's efforts to include you and your child in decisions about your child's care	○	○	○	○	○
5. Instructions on what to do if experiencing problems related to your child's condition (when to seek help, who to call, etc.)	○	○	○	○	○
6. Degree of safety and security you felt in our facility	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 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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