

Pediatric Outpatient Behavioral Health (OY0102)



Dear {FIRST_NAME} {LAST_NAME}, or parent or guardian of:

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 on {DISDATE}, 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".

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

[Start Survey](#)



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 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.

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.

OMB No. 0925-0648 Expiration Date: 06/2024

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).

[Continue](#)

PEDIATRIC OUTPATIENT SURVEY

0%

ACCESS

Ease of getting an appointment

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Convenience of available appointment times

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comments (describe good or bad experience):

PEDIATRIC OUTPATIENT SURVEY

15%

CLINICAL AREA

Cleanliness of the clinical area

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Privacy of the clinical area

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comfort level in and around the clinical area

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comments (describe good or bad experience):

PEDIATRIC OUTPATIENT SURVEY

29%

CARE PROVIDERS

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). PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

Courtesy and respect of the care provider

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Helpfulness of time your child spent with the care provider

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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How well the care provider informed you and your child about your child's medication (if your child was prescribed medication)

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comments (describe good or bad experience):

PEDIATRIC OUTPATIENT SURVEY

43%

THERAPIST(S)

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

Your trust in the skill of the therapist(s)

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Therapist's concern for your child's questions and worries

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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How well the therapist(s) understood your child and their needs

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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How well the therapist(s) kept you informed about your child's treatment

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Therapist(s) Section Comments

PEDIATRIC OUTPATIENT SURVEY

58%

YOUR CHILD'S CARE

Staff's concern for your child's privacy

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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How well the staff addressed your child's emotional needs

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Staff's response to concerns/complaints made during your child's care

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Staff's efforts to include you and your child in decisions about your child's care

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Instructions on what to do if experiencing problems related to your child's condition (when to seek help, who to call, etc.)

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Degree of safety and security you felt in our facility

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comments (describe good or bad experience):

PEDIATRIC OUTPATIENT SURVEY

72%

OVERALL ASSESSMENT

How well the staff worked together to care for your child

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Overall rating of care given at this facility

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Likelihood of your recommending this facility to others

Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5
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Comments (describe good or bad experience):

PEDIATRIC OUTPATIENT SURVEY

86%

Patient's Name: (optional)

Parent or Guardian's Name: (optional)

Telephone Number: (optional)