"HOW WAS YOUR SURGICAL EXPERIENCE?" at PALOS HILLS SURGERY CENTER

Our management staff is continually looking for ways to provide the very best service and care to our patients. Your perceptions of care, treatment and services are of great importance, and help us evaluate the care our patients receive. Please return this survey to us in the postage-paid envelope provided. Thank you for your cooperation!

NAME (Optional)_____ Surgery Date _____ Surgeon _____

3) Give us a grade on the following aspects of care, treatment and services: (Circle)

	Excellent			Poor		
Facility Appearance	A	B	C	D	F	
Reception Personnel	A	B	C	D	F	
Nursing Personnel	A	B	C	D	F	
Anesthesia Personnel	A	B	C	D	F	NA
Pre-Operative Teaching & Instructions	A	B	C	D	F	
Post-Operative Teaching & Instructions	A	B	C	D	F	
Effectiveness of Pain Management	A	B	C	D	F	NA
On-Line Health History (Medical Passport)	A	B	C	D	F	
Billing Services	A	B	C	D	F	
Telephone and Voice Mail System	A	B	C	D	F	
Your Companion's Experience	A	B	C	D	F	NA
The Experience Overall	A	B	C	D	F	

4) Do you have any suggestions for how we might improve patient safety? **YES** **NO**

Comment_____

_____

5) If necessary, would you have surgery at the surgery center again? **YES** **NO**

Comment_____

_____

6) Would you recommend the surgery center to someone you know who needed outpatient surgery?

YES **NO**

Comment_____

_____

7) What could we have done to improve your surgical experience at the surgery center? _____

_____

_____

(Use Reverse Side If More Space Is Needed)