



## PATIENT SATISFACTION EVALUATION

Please take a moment to evaluate your experience at Research Psychiatric Center (RPC). We are continually working to improve our services and invite you to comment on any positive or negative experience you may have had during your stay. **Circle** the answer that best represents your experience. Return the evaluation to the RPC receptionist or mail to RPC in the enclosed envelope.

**BACKGROUND INFORMATION:**

1. Who is filling out the survey?     Patient     Parent/Guardian     Spouse     Relative/Friend
2. Date of admission: \_\_\_\_\_                      Date of discharge: \_\_\_\_\_
3. Patient's age: \_\_\_\_\_
4. Patient's sex:     Male     Female
5. Physician's name: \_\_\_\_\_

**PROMPTNESS AND COURTESY OF ADMISSIONS PROCEDURE:**

	non-applicable	poor	fair	good	very good
1. Courtesy of Receptionist	<input type="checkbox"/>	1	2	3	4
2. Courtesy of Intake Assessment staff	<input type="checkbox"/>	1	2	3	4
3. Courtesy of Admissions staff	<input type="checkbox"/>	1	2	3	4
4. Timeliness of Admission procedure	<input type="checkbox"/>	1	2	3	4
5. How well were procedures and regulations explained	<input type="checkbox"/>	1	2	3	4
6. How well were you introduced to your unit	<input type="checkbox"/>	1	2	3	4

Comments/Suggestions \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**YOUR ROOM/ACCOMMODATIONS:**

non-applicable	poor	fair	good	very good
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- |  |                          |   |   |   |   |
|--|--------------------------|---|---|---|---|
| 1. Courtesy of Housekeeping staff                          | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 2. Cleanliness of your room                                | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 3. Cheerfulness of your room                               | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 4. Room temperature  | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 5. Courtesy of Plant Operations staff while making repairs | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 6. Noise level on your unit                                | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 7. Space adequate for meeting with family/visitors         | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 8. Overall appearance of the facility                      | <input type="checkbox"/> | 1 | 2 | 3 | 4 |

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOOD SERVICE:**

- |   |                          |   |   |   |   |
|---|--------------------------|---|---|---|---|
| 1. Courtesy of Food Service staff   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 2. Cleanliness of Cafeteria area  | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 3. Presentation of menu items   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 4. Quality and temperature of food served                                 | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 5. If you had a special/restricted diet, how well was it explained to you | <input type="checkbox"/> | 1 | 2 | 3 | 4 |

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NURSING CARE:**

- |   |                          |   |   |   |   |
|---|--------------------------|---|---|---|---|
| 1. Courtesy of the nursing staff                                | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 2. Promptness in responding to your needs                       | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 3. Were your health problems taken seriously                    | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 4. How well were you kept informed regarding Treatment          | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 5. Nursing staff addressed your requests in a reasonable manner | <input type="checkbox"/> | 1 | 2 | 3 | 4 |

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT PROGRAM:**

non-applicable	poor	fair	good	very good
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- |  |                          |   |   |   |   |
|--|--------------------------|---|---|---|---|
| 1. Courtesy of Social Work staff   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 2. Courtesy of Case Management staff                                     | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 3. Courtesy of OT/RT Staff (art, gym, stress management/relaxation)      | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 4. Helpfulness of group sessions   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 5. Helpfulness of family therapy program                                 | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 6. Individual counseling sessions  | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 7. Degree of your involvement in treatment plan                          | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 8. Amount of time your Social Worker spent with you                      | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 9. If you had Electroconvulsive Therapy (ECT), Courtesy of the ECT staff | <input type="checkbox"/> | 1 | 2 | 3 | 4 |

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISCHARGE:**

- |  |                          |   |   |   |   |
|--|--------------------------|---|---|---|---|
| 1. Courtesy of Business Office staff   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 2. Helpfulness of Business Office in understanding your bill, and arranging for payment                    | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 3. Instructions on what to do if you experience problems after discharge related to your medical condition | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 4. Information provided regarding your medication  | <input type="checkbox"/> | 1 | 2 | 3 | 4 |
| 5. Degree of involvement in discharge plan   | <input type="checkbox"/> | 1 | 2 | 3 | 4 |

Comments/Suggestions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

