

MAIL TO:
The Surgery Center of Farmington
400 Parkland Dr.
Farmington, MO 63640
573-756-8000
www.thesurgerycenteroffarmington.com

DATE: _____

Dear Patient:

Please rate our performance by checking the response that best describes your evaluation. Feel free to add comments. Upon completion, please return to us. Thank you for your input and feedback.

	Excellent	Good	Poor	Very Poor
ADMITTING/REGISTRATION				
1. Professional and courteous service of office staff	_____	_____	_____	_____
2. Speed and efficiency of registration	_____	_____	_____	_____
3. Satisfactory answers to financial and insurance questions.	_____	_____	_____	_____
NURSING				
4. Professional and courteous service of nurses	_____	_____	_____	_____
5. Nurses introducing themselves and keeping you informed	_____	_____	_____	_____
6. Nurses explaining procedures	_____	_____	_____	_____
7. Satisfactory answers to questions	_____	_____	_____	_____
8. Written instructions for your home care	_____	_____	_____	_____
OVERALL				
9. Staff giving you the privacy you needed	_____	_____	_____	_____
10. Cleanliness and comfort of the surgery center	_____	_____	_____	_____
11. Likelihood that you would return or recommend the Surgery Center to others	_____	_____	_____	_____
12. OVERALL , rating of your experience at the Surgery Center	_____	_____	_____	_____

Additional Comments: _____

Optional Information:

Name: _____

Address: _____