Research
PSYCHIATRIC CENTER
HCA Midwest HEALTH SYSTEM®

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	☐	1	2	3	4
2. Courtesy of Intake Assessment staff	☐	1	2	3	4
3. Courtesy of Admissions staff	☐	1	2	3	4
4. Timeliness of Admission procedure	☐	1	2	3	4
5. How well were procedures and regulations explained	☐	1	2	3	4
6. How well were you introduced to your unit	☐	1	2	3	4

Comments/Suggestions_____
_____
_____
_____

YOUR ROOM/ACCOMMODATIONS:	non-applicable	poor	fair	good	very good
1. Courtesy of Housekeeping staff	☐	1	2	3	4
2. Cleanliness of your room	☐	1	2	3	4
3. Cheerfulness of your room	☐	1	2	3	4
4. Room temperature	☐	1	2	3	4
5. Courtesy of Plant Operations staff while making repairs	☐	1	2	3	4
6. Noise level on your unit	☐	1	2	3	4
7. Space adequate for meeting with family/visitors	☐	1	2	3	4
8. Overall appearance of the facility	☐	1	2	3	4

Comments/Suggestions: _____

_____

_____

_____

FOOD SERVICE:					
1. Courtesy of Food Service staff	☐	1	2	3	4
2. Cleanliness of Cafeteria area	☐	1	2	3	4
3. Presentation of menu items	☐	1	2	3	4
4. Quality and temperature of food served	☐	1	2	3	4
5. If you had a special/restricted diet, how well was it explained to you	☐	1	2	3	4

Comments/Suggestions: _____

_____

_____

_____

NURSING CARE:					
1. Courtesy of the nursing staff	☐	1	2	3	4
2. Promptness in responding to your needs	☐	1	2	3	4
3. Were your health problems taken seriously	☐	1	2	3	4
4. How well were you kept informed regarding Treatment	☐	1	2	3	4
5. Nursing staff addressed your requests in a reasonable manner	☐	1	2	3	4

Comments/Suggestions:_____

_____

_____

_____

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

Comments/Suggestions: _____

_____

_____

_____

DISCHARGE:					
1. Courtesy of Business Office staff	☐	1	2	3	4
2. Helpfulness of Business Office in understanding your bill, and arranging for payment	☐	1	2	3	4
3. Instructions on what to do if you experience problems after discharge related to your medical condition	☐	1	2	3	4
4. Information provided regarding your medication	☐	1	2	3	4
5. Degree of involvement in discharge plan	☐	1	2	3	4

Comments/Suggestions: _____

_____

_____

_____

PHYSICIAN:	non-applicable	poor	fair	good	very good
1. Courtesy of physician	☐	1	2	3	4
2. Amount of time spent with you	☐	1	2	3	4
3. Information provided by physician about your treatment/medications	☐	1	2	3	4

Comments/Suggestions: _____

_____

_____

_____

OTHER AREAS:					
1. Was your privacy respected at all times	☐	1	2	3	4
2. Staff sensitive to your needs	☐	1	2	3	4
3. Degree to which you feel your condition has improved as a result of your stay at our hospital	☐	1	2	3	4
4. Likelihood of recommending RPC to others	☐	1	2	3	4
5. How safe did you feel in the hospital environment	☐	1	2	3	4

Suggestions for improving safety at the hospital:_____

_____

_____

Additional Comments/Suggestions: _____

_____

_____

_____

OVERALL SATISFACTION WITH YOUR HOSPITAL STAY	1	2	3	4

(Optional) Patient's Name: _____