

Montvale Surgical Center, LLC

6 Chestnut Ridge Road, Montvale, NJ 07645

Tel: 201-391-4700 Fax: 201-391-4701

Patient Satisfaction Questionnaire

We want to thank you for giving us the opportunity to care for you. It is important to us to know how our care impacted on you and your guests. Your input is greatly appreciated, and we would like to request a few minutes of your time to fill out the following survey.

Thank you.

Registration:

1. Was the Center easy to locate? Yes No
2. Was the registration process easy and friendly? Yes No
3. Was the registration staff courteous, helpful and friendly? Yes No
4. Was the waiting area comfortable? Yes No
5. Were your guests and/or family kept informed of your progress? Yes No

Before Surgery:

1. Preoperative instructions were provided by: Doctor's Office Surgery Center
2. Was preoperative communication with the Surgery Center helpful? Yes No
3. Were all of your questions answered satisfactorily? Yes No

Pre-Operation:

1. Was the Pre-op area comfortable? Yes No
2. Was the Pre-op staff courteous, helpful and friendly? Yes No

Operating Room:

1. Did the O.R. staff make you feel comfortable and at ease with your procedure? Yes No
2. Was the O.R. staff courteous, helpful and friendly? Yes No

Recovery/Discharge:

1. Were your questions answered to your satisfaction? Yes No
2. Were the instructions about your procedure and follow-up care helpful? Yes No

Please comment: _____

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3. Was the staff in this area courteous, helpful and friendly? Yes No
 4. Was the follow-up call helpful and reassuring? Yes No

Overall Satisfaction:

1. Were you pleased with the care provided by your surgeon? Yes No
Surgeon's Name (optional): _____
2. Were you pleased with the care provided by your anesthesiologist? Not applicable Yes No
Anesthesiologist's Name (optional): _____
3. Overall, was your experience with the Surgery Center positive? Yes No
4. Do you have any suggestions on how we can improve our service? Additional comments on these or other issues would be greatly appreciated:

Survey completed by: Patient Other: _____ Date: _____
(Please specify relationship)

Your Name (optional): _____ Tel (optional): _____