

**Patient Experience Survey**

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| **Date of your last visit:** | | | |  | | | | | | | | | | | **Type of visit:** | | | | | | | Scheduled Appointment | | | | | | | | | | | | | |  | | | | | | Walk-In Visit | | | | | | | | | |  | | | |
| **Please mark the area(s) where you last received services:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |
| Adult Medical | |  | Ob/Gynecology | | | | | |  | | Behavioral Health | | | | | | | | |  | Alcohol/Substance Abuse | | | | | | | | | | | | |  | | | | | Lab | | | | | |  | | | |  | | |  | | | |
| Pediatrics |  | Pharmacy | | | |  | Dental | | | | |  | Dietary | | |  | | Physical Therapy | | | | | | |  | | | Fitness | | | |  | | | | | Diabetes | | | | | | |  | | |  | | | | | | |
| **OPTIONAL: Please list your race/ethnicity:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |
| Native American/Alaskan Native | | | | | | | |  | | Hispanic/Latino | | | | | | |  | | African American | | | | | | |  | | | Asian | |  | | | | | | | Caucasian | | | | | | | |  | | | | Other | | | | |  |
| **Care Team Relationships:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Yes** | | | | | |  | | **No** | | | | |  | | |  | | | | |
| 1. During your last visit, did staff listen carefully to you? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | |  | | | | |  | | |  | | | | |
| 1. During your last visit, was staff respectful, caring, and helpful? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | |  | | | | |  | | |  | | | | |
| 1. Does your provider know important information about your health history? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | |  | | | | |  | | |  | | | | |
| 1. In the last 12 months, how often does your provider and Care Team answer your questions and explain things in a way that are easily understood? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Always** | | | | | | | | **Usually** | | | | | **Sometimes** | | | | | | | **Never** | | |
| **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| **Quality of Care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Always** | | | | | | | | **Usually** | | | | | **Sometimes** | | | | | | | **Never** | | |
| 1. Do you have confidence in the care you receive from your provider? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| **Access/Facility:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Always** | | | | | | | | **Usually** | | | | | **Sometimes** | | | | | | | **Never** | | |
| 1. In the last 12 months, how often did you get an appointment as soon as you needed it or wanted it? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. In the last 12 months, were you able to see the provider of your choice? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. Are your calls returned on time? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. How long did you spend in the waiting room? | | | | | | | | | | | | | | < 15 minutes | | | | | | | | |  | | | | 15-30 Minutes | | | | | | | | | | | | |  | | | >..30 minutes | | | | | | | | | |  | | |
| **Comprehensive of Care:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Always** | | | | | | | | **Usually** | | | | | **Sometimes** | | | | | | | **Never** | | |
| 1. Does your Provider/Care Team address all of your health care needs and concerns? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. Does your Provider/Care Team explain your treatment plan and the medications you   are taking in a way that is easy for you to understand? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. Does your Provider/Care Team speak with you about making healthy lifestyle   changes to help prevent illness? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| **Coordination of Care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Always** | | | | | | | | **Usually** | | | | | **Sometimes** | | | | | | | **Never** | | |
| 1. In the last 12 months, when you needed a referral, were you given all the information  you needed to be prepared and get to your appointment? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| 1. In the last 12 months, did you get your lab or other test results in a timely, confidential  manner? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **\_\_\_\_\_** | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| **How would you rate your overall health care experience at your last visit?** | | | | | | | | | | | | | | | | | | | | | | | | **Excellent** | | | | | | **Very Good** | | | | | | | | | | | **Good** | | | | | **Fair** | | | | | | | **Poor** | | |
| **\_\_\_\_\_** | | | | | | **\_\_\_\_\_** | | | | | | | | | | | **\_\_\_\_\_** | | | | | **\_\_\_\_\_** | | | | | | | **\_\_\_\_\_** | | |
| **Would you refer your friends or family to the Gerald Ignace Indian Health Center?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Yes** | | | | | | | | | | | **\_\_\_\_\_** | | | | | **No** | | | | | | | **\_\_\_\_\_** | | |
| If no, Please state why: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other comments about your visit or ideas you would like to share for improving programs and services:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please complete the following if you would like someone to contact you in response to this survey:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***TEXT MESSAGING CONCERNS OR COMPLAINTS:*** If you wish to leave a confidential text message about a concern or complaint you have related to the services you received, please text the number: (414) 531-4128. Someone will investigate your concerns and respond to you within 24 hours.  ***All information is maintained confidentially - thank you for sharing your ideas for improvement!*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |