

**Patient Experience Survey**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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!*** |