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?	____	____
2) During your last visit, was staff respectful, caring, and helpful?	____	____
3) Does your provider know important information about your health history?	____	____

	Always	**Usually**	**Sometimes**	**Never**
4) 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?	____	____	____	____
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?	____	____	____	____
2) In the last 12 months, were you able to see the provider of your choice?	____	____	____	____
3) Are your calls returned on time?	____	____	____	____

4) 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?	____	____	____	____
2) 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?	____	____	____	____
3) 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?	____	____	____	____
2) In the last 12 months, did you get your lab or other test results in a timely, confidential manner?	____	____	____	____

	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
How would you rate your overall health care experience at your last visit?	___	___	___	___	___

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!