"HOW WAS YOUR SURGICAL EXPERIENCE?" at MIDWEST CENTER FOR DAY SURGERY

Our management staff continually looks for ways to provide the very best service and care to our patients. Your perceptions of care, treatment and services are very important to us and help us evaluate the care our patients receive. Please return this survey to us in the enclosed postage-paid envelope. Thank you for your cooperation!

NAME (Optional)_____ **Surgery Date** _____ **Surgeon** _____

1) Give us a grade on the following aspects of care, treatment and services : (Circle your response)

	Excellent			Poor		
Facility Appearance	A	B	C	D	F	
Reception Personnel	A	B	C	D	F	
Nursing Personnel	A	B	C	D	F	
Anesthesia Personnel	A	B	C	D	F	NA
Pre-Operative Teaching & Instructions	A	B	C	D	F	
Post-Operative Teaching & Instructions	A	B	C	D	F	
Effectiveness of Pain Management	A	B	C	D	F	
On-Line Health History (Medical Passport)	A	B	C	D	F	
Patient Texting Service	A	B	C	D	F	NA
Surgery Center Website	A	B	C	D	F	
Billing Department	A	B	C	D	F	
Telephone and Voice Mail System	A	B	C	D	F	
Your Companion's Experience	A	B	C	D	F	NA
The Experience Overall	A	B	C	D	F	

2) Do you have any suggestions for how we might improve patient safety? **YES** **NO**

Comment_____

_____

3) During your stay did you see your doctors and/or nurses clean their hands? Please explain. **YES** **NO**

Comment_____

_____

4) If necessary, would you have surgery at MCDS again? **YES** **NO**

Comment_____

_____

5) Would you recommend MCDS to someone you know who needed outpatient surgery? **YES** **NO**

Comment_____

_____

6) What could we have done to improve your surgical experience at MCDS?_____

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(Use Reverse Side If More Space Is Needed)