OUTPATIENT SURGERY CENTER AT THE VILLAGES OF BERT KOUNS

- Thank you in advance for completing this questionnaire as soon as possible about your recent visit to this Center. We assure you that your responses are strictly confidential. Your reports will help us improve the care we provide to all patients.
- Answer the questions by placing an 'x' in the box that best reflects your response.
- Please complete both front and back of this survey.

*Patient name (optional): _____ Surgeon name: _____
*Date of Surgery: _____ Date completing this survey: _____

YOUR CARE FROM YOUR NURSES	**NEVER**	**SOMETIMES**	**USUALLY**	**ALWAYS**
1. During your visit to the Center, how often did the nurses treat you with courtesy and respect?	☐ 1	☐ 2	☐ 3	☐ 4
2. During your visit, how often did nurses listen carefully to you?	☐ 1	☐ 2	☐ 3	☐ 4
3. During your visit, how often did nurses explain things in a way you could understand?	☐ 1	☐ 2	☐ 3	☐ 4
4. During your visit, how often were your needs met in a timely manner?	☐ 1	☐ 2	☐ 3	☐ 4

YOUR CARE FROM YOUR SURGEON	**NEVER**	**SOMETIMES**	**USUALLY**	**ALWAYS**
5. During your visit to the Center, how often did the surgeon treat you with courtesy and respect?	☐ 1	☐ 2	☐ 3	☐ 4
6. During your visit, how often did surgeon listen carefully to you?	☐ 1	☐ 2	☐ 3	☐ 4
7. During your visit, how often did surgeon explain things in a way you could understand?	☐ 1	☐ 2	☐ 3	☐ 4
8. During your visit, how often were your needs met in a timely manner?	☐ 1	☐ 2	☐ 3	☐ 4

YOUR CARE FROM YOUR ANESTHESIA PROVIDER	**NEVER**	**SOMETIMES**	**USUALLY**	**ALWAYS**
9. During your visit to the Center, how often did the anesthesia provider treat you with courtesy and respect?	☐ 1	☐ 2	☐ 3	☐ 4
10. During your visit, how often did the anesthesia provider listen carefully to you?	☐ 1	☐ 2	☐ 3	☐ 4
11. During your visit, how often did the anesthesia provider explain things in a way you could understand?	☐ 1	☐ 2	☐ 3	☐ 4

YOUR CENTER EXPERIENCE

	NEVER	SOMETIMES	USUALLY	ALWAYS
12. During your visit, how often was your pain well controlled?	☐ 1	☐ 2	☐ 3	☐ 4
13. During your visit, how often was the environment around you kept clean?	☐ 1	☐ 2	☐ 3	☐ 4

14. During your visit, did you get information in writing about symptoms or health problems to look for after leaving the Center? ☐ **YES** ☐ **NO**

	NEVER	SOMETIMES	USUALLY	ALWAYS
15. Did the staff demonstrate concern for your personal safety?	☐ 1	☐ 2	☐ 3	☐ 4

OVERALL RATING OF OUR CENTER

16. Using any number from 0 to 10, where 0 is the worst Center possible and 10 is the best Center possible, what number would you use to **rate** the Center during your stay?

Worst ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Best**

	Definitely No	Probably No	Probably Yes	Definitely Yes
17. Would you recommend this Center to others?	☐	☐	☐	☐
18. Would you recommend this Center to a family member or friend?	☐	☐	☐	☐

RETURN TO YOUR NORMAL ACTIVITIES

19. I ☐ **did not** experience any signs of infection (increased temperature, foul odor/drainage, severe redness at incision)

I ☐ **did** experience signs of infection which included:

_____

	YES	NO
20. Did you witness your care givers washing their hands before and after making contact with you?	☐	☐
21. Did you feel safe while under our care?	☐	☐

***PLEASE LIST TWO AREAS WHERE WE COULD POSSIBLY IMPROVE:**

1) _____

2) _____

***COMMENTS:** _____

_____

_____

ACCNT#: _____

DOS: _____

*****THANK YOU FOR PARTICIPATING IN THIS IMPORTANT SURVEY!*****
Please return the completed survey in the postage paid envelope or
Email back to: bbryan@oscshreveport.com **or**
Fax back to: (318) 212-0557