Your Hospital's Logo Here

SLEEP DISORDERS INSTITUTE
HOSPITAL: DePaul Building
Street Address
City, State Zip
Tel: (202) 555 - 1212
Fax: (202) 555 - 1212

PATIENT SATISFACTION SURVEY

THANK YOU for using the Sleep Disorder Center at Your Hospital to serve your health care needs. We hope that your experience with us was a positive one, and that we contributed to your care by providing valuable information to you and your health care providers. Please complete this survey and return it to us at your convenience.

PATIENT NAME: _____ DATE: _____

TECHNOLOGIST(S) ON DUTY: _____

How many days was it between the time you requested an appointment for office visit and the time you were seen?

☐ 1 - 7 ☐ 8 - 14 ☐ 15 - 21 ☐ 22 - 28 ☐ ≥29 ☐ N/A

How many days was it between the time you requested an appointment for an overnight laboratory test and the time you were seen?

☐ 1 - 7 ☐ 8 - 14 ☐ 15 - 21 ☐ 22 - 28 ☐ ≥29 ☐ N/A

	PLEASE RATE US				
	EXCELLENT	GOOD	FAIR	BELOW FAIR	POOR
Courtesy of reception staff	☐	☐	☐	☐	☐
Ability to get a timely appointment	☐	☐	☐	☐	☐
Location of facility	☐	☐	☐	☐	☐
Dress and appearance of staff	☐	☐	☐	☐	☐
Knowledge of staff	☐	☐	☐	☐	☐
Professionalism of staff	☐	☐	☐	☐	☐
Doctor's patience and interest in you	☐	☐	☐	☐	☐
Timeliness of report(s) following testing	☐	☐	☐	☐	☐
Timeliness of medication or CPAP orders	☐	☐	☐	☐	☐
Comfort of office and laboratory facilities	☐	☐	☐	☐	☐
Overall quality of the service you received	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

Do you have additional comments? If so, check here ☐ and write additional comments on back of survey.

THANK YOU *from the Staff of Your Hospital's Sleep Disorders Institute*