Your Clinic Name/Logo

Patient Experience Survey

Your responses to the questions on this survey will help us improve the care we provide. Participation in the survey is completely voluntary and all your responses to the survey will be kept confidential.

1. **The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your Nurse Practitioner to when you actually saw her/him or someone else in their office?**
   ○ Same day ○ Next day ○ 2-19 days (enter # of day ______)
   ○ 20 or more days ○ Not applicable (don't know/ refused)

2. **Did you get an appointment on the day you wanted or within an acceptable timeframe?**
   ○ Yes ○ No

3. When you see your Healthcare Providers, how <u>often</u> do they or someone else in the office…?	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
a. Give you an opportunity to ask questions about recommended treatment	○	○	○	○	○
b. Involve you as much as you want to be in decisions about your care/treatment	○	○	○	○	○
c. Spend enough time with you	○	○	○	○	○

4. **a) How many times in the past 12 months have you received care from a walk-in clinic or Emergency Department?**
   ○ None ○ 1-3 ○ 4-6 ○ 7-9 ○ 10+
   b) If you have received care from a walk-in clinic or Emergency Department, what was the reason for the visit?
   ○ Appointment was not available at this clinic ○ It was evening / week-end / holiday
   ○ Other, please specify: ____________________

5. **a) Have you been hospitalized in the past 12 months?** ○ Yes ○ No
   b) If yes, did you book a follow-up appointment with this clinic? ○ Yes ○ No
   (Note: We strongly recommend you book a post-hospital discharge follow-up within 7 days)

6. **a) Do you take prescription medication(s) on an ongoing basis?** ○Yes ○ No
   b) If yes, in the past 12 months, did you review your medications with your Nurse Practitioner and/or Pharmacist? ○ Yes ○ No ○ Don't know/Unsure

PLEASE TURN OVER

Your Clinic Name/Logo

7. **We are a Team-Based healthcare model. Please let us know whom you saw in the past 12 months?** Please check **ALL** that apply.
   ○ Nurse practitioner ○ Nurse ○ Social Worker ○ Dietitian ○ Physician
   ○ Other, please specify: _______________

8. **Do you feel you have received comprehensive care by seeing a team of health care professionals?** ○ Yes ○ No

9. **Overall, how would you rate your experience with this clinic?**
   ○ Poor ○ Fair ○ Good ○ Very good ○ Excellent

10. **Would you recommend our services to friends or your family?**
    ○ Definitely no ○ Probably no ○ Probably yes ○ Definitely yes

11. **Please list any areas in which our service could be improved or any other comments/suggestions about our clinic.**

    ____

    ____

    May we add your comments to our website? ○ Yes ○ No

Thank you for completing our survey!