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Patient Feedback Form

OPD FEEDBACK FORM

We thank you for choosing Hospital Name as your healthcare partner. In order to improve our services we request you to spare some time and give your valuable feedback.

1. Please rate courteous behaviour & promptness of the Billing/reception counter staff.

   Excellent Good Fair Poor Unacceptable

2. How long did you wait to see the doctor after Billing was done?

   Excellent <10 Min Good <20 Min Fair<30 min Poor >30 min Unacceptable ___min

3. Please rate your experience with doctors.

   Excellent Good Fair Poor Unacceptable

4. Please rate your experience with Nursing Staff.

   Excellent Good Fair Poor Unacceptable

5. Please rate your experience with pathology/laboratory/blood investigation services.

   Excellent Good Fair Poor Unacceptable

6. Please rate your experience with Hospital Pharmacy Services.

   Excellent Good Fair Poor Unacceptable

7. Please rate your experience with Hospital Ambiance, washroom cleanliness and waiting area.

   Excellent Good Fair Poor Unacceptable

8. Will you **prefer** to visit again in future for your health care needs? ☐ Yes ☐No
9. Will you **refer others** to visit Hospital Name? ☐Yes ☐No
10. Please write suggestions or remarks for any of the above service if rated as Poor/Unacceptable:_____

_____

Can we share your feedback on social media platform ☐Yes ☐No

Your Name: Date: Time:

Doctor's Name: Mobile Number: Bill Number:

CAREGIVER'S AND PATIENTS FEEDBACK FORM

Read the following items and tick (√)as you feel papropriate. This will bre kept confidential and your identity will not be revealed:

NAME: **P/NO:**

#	ITEM	Good	Average	Poor
1	Admission process			
2	Explanation on word routines and policies			
3	Cleanliness:			
	a) Wards			
	b) Bathrooms			
	c) Toilets			
4	Maintenance of bed			
5	Quality of food			
6	Safety and comfort			
7	Maintenance of privacy and dignity during procedures like dressing injection etc			
8	Health education regarding personal hygenie, medication compliance etc..			
9	Attitude towards patients			
	a) Doctors			
	b) Nurses			
	c) House keeping staff			
10	Response to emergency needs			
11	Discharge process			
	a) Billing/ Account settlement			
	b) Discharge summary and prescription			
	c) Explanation about follow up dae medications			
12	Overall satisfction			

Comments/suggestion:

Signature:
Date:

Disclaimer

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