



Lawrenceville Surgery Center Patient Satisfaction Survey Injection Patients

Thank you for choosing our Center for your procedure. We are committed to providing you with quality medical care, and your satisfaction is very important to us. Because our success is measured by your evaluation of our performance, we ask that you take a moment to answer the following questions. We assure you that your responses will be kept confidential and will not be used for anything other than researching ways to continually enhance our services. Once you have completed the survey, please return it as the postage has been pre paid. Thank you in advance for your cooperation with this research effort. Your response is very important to the validity of this study.

	Completely Satisfied	Somewhat Satisfied	Neither	Somewhat Dissatisfied	Completely Dissatisfied	Does Not Apply
1. Instructions & explanations given prior to your surgery or procedure	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
2. Discussion of your insurance or financial arrangements	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
3. Registration and check-in on the day of your procedure	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
4. Medical competency and care given by your physician	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
5. Cleanliness and comfort of the facility environment	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
6. Respect for your privacy/confidentiality.....	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
7. Quality of nursing care received.....	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x
8. Promptness of your procedure begin time.....	<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> -x

YOUR OVERALL VISIT:

If you require outpatient surgery or procedures in the future, how likely would you be to return to our facility

Definitely Would Probably Would Might or Might Not Probably Would Not Definitely Would Not

<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1
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How likely would you be to recommend our facility to a friend or family member who needs outpatient surgery or procedures

<input type="checkbox"/> -5	<input type="checkbox"/> -4	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1
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What else could our facility and its staff members do to better meet your needs in the future? **(PLEASE WRITE ANY COMMENTS IN THE BLANKS BELOW. USE A SEPARATE SHEET OF PAPER IF ADDITIONAL SPACE IS NEEDED)**

(OPTIONAL) If you would like a representative to contact you about a specific need or issue, please write in your name and phone number below.

NAME: _____ PHONE: (_____) _____ - _____