UROLOGY ASSOCIATES, P.C.

Day-Op Center 533 Plandome Rd. Manhasset, NY 11030
(516) 466-9737 phone/ (516) 466-9739 fax

	Very Poor 1	poor 2	fair 3	good 4	Very good 5

A. Facility

	1	2	3	4	5
1. Comfort of the registration waiting area	○	○	○	○	○
2. Comfort of the recovery area	○	○	○	○	○
3. Comfort of the waiting area for your family	○	○	○	○	○
4. Attractiveness of the Surgery Center	○	○	○	○	○
5. Cleanliness of the Surgery Center	○	○	○	○	○
6. Convenience of parking	○	○	○	○	○

Comments (please describe a particularly good or bad experience):

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B. Anesthesia/Anesthesiologist

	1	2	3	4	5
1. Anesthesiologist's explanation of your procedure	○	○	○	○	○
2. Courtesy and friendliness of the anesthesiologist	○	○	○	○	○

Comments:______________________________________

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C. Before Your Surgical Procedure

	1	2	3	4	5
1. Waiting time before your surgical procedure began	○	○	○	○	○
2. Friendliness/courtesy of the physician	○	○	○	○	○
3. Explanation the physician gave you about what the surgical procedure would be like	○	○	○	○	○
4. Friendliness/courtesy of the staff	○	○	○	○	○
5. Information staff gave you on the day of your procedure	○	○	○	○	○

6. Instructions you were given by our staff about how to prepare for your surgical procedure………….……………………………… ○ ○ ○ ○ ○

Comments:____
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D. After Your Surgical Procedure

1. Staff concern for your comfort while you were in recovery...……… ○ ○ ○ ○ ○
2. Information the physician provided about what was done during your surgical procedure…….……………………………………...… ○ ○ ○ ○ ○
3. Information staff gave your family after your surgical procedure….. ○ ○ ○ ○ ○
4. Instructions staff gave about caring for yourself at home…………... ○ ○ ○ ○ ○
5. Your confidence in the skill of the staff…………………………….. ○ ○ ○ ○ ○

Comments:____
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E. Personal Issues

1. Information provided about delays (if you experienced delays)…… ○ ○ ○ ○ ○
2. Our concern for your privacy………………………………………. ○ ○ ○ ○ ○
3. Degree to which your pain was controlled…………………………. ○ ○ ○ ○ ○
4. Response to concerns/complaints made during your visit………… ○ ○ ○ ○ ○
5. Degree to which staff treated you with respect and dignity………… ○ ○ ○ ○ ○
6. Degree of safety and security felt in facility………………………… ○ ○ ○ ○ ○

Comments:____
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F. Overall Assessment

1. Overall rating of care received during your visit…………………… ○ ○ ○ ○ ○
2. Degree to which staff worked together to care for you…………….. ○ ○ ○ ○ ○

3. Likelihood of your recommending our office .... ○ ○ ○ ○ ○

4. Likelihood of returning to this office for future services.............. ○ ○ ○ ○ ○

Comments:____
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Patient's Name (optional) ____

Telephone Number (optional)____

Treating Physician (optional)____