



Patient Care Survey

Thank you for your participation in this survey. It will take approximately 5 minutes to complete. Your responses will be kept anonymous and data collected will be used to improve the quality of care provided by Coastal Radiology.

Reason for your visit today? Pain Procedure Vein Procedure Other

How did you hear about us? Physician Referral TV Ad Friend Other

Are you a new patient? Yes No

Please rate the following:	Poor	Fair	Very Good	Excellent	N/A
Treatment at the time of scheduling?					
Was check-in and check-out with reception acceptable?					
Length of time waiting in the reception area?					
Treatment by the reception staff?					
Treatment by the technologist/radiologist assistant?					
Treatment by the nurse(s)?					
Treatment by the physician? (if applicable)					
Satisfied with information I received about my procedure and the follow-up process?					
Were all questions or concerns about your procedure addressed appropriately?					
Staff had all medical history related to the procedure to be performed?					
Personnel spent enough time with me?					
Received information about accessing the online Patient Portal to view visit summary and communicating with my provider?					
I am pleased with the care I received?					
I would recommend Coastal Radiology to others?					

Comments and Suggestions: Please use back of sheet if more space is needed):

We sometimes contact our patients directly to discuss opinions and get further suggestions. May we contact you if needed?
 Yes No If Yes, provide a contact phone number: _____

Printed Name

Date

This survey is for a government incentive program and quality improvement feedback. Your responses will be kept anonymous and will not negatively affect the radiologic staff or your future healthcare.