PLEASE TAKE A MOMENT TO FILL OUT THIS FORM AND RETURN IT TO YOUR DOCTOR'S OFFICE TOMORROW.

Eye Surgery Center OF MICHIGAN

To Our Patients:

Our facility is committed to delivering the highest quality of care to you. We want you to know that we are continually looking for better ways to serve your needs. You can help by answering the following questions. You are the reason we are here and we want to know how we treated you. Thank you!

Please grade the questions using the scale provided. Please (X) the appropriate grade	**Poor F**	**Fair D**	**Average C**	**Good B**	**Excellent A**	**N/A**
1. The date and time of your procedure were clearly reviewed.						
2. Your reception was courteous and prompt.						
3. The staff treated you with respect and kindness.						
4. You received sufficient information to prepare you for your surgical visit.						
5. Your confidentiality was maintained.						
6. The environment was clean and comfortable.						
7. The staff were available to answer questions and explain procedures.						
8. You and your care giver were given adequate instructions for follow-up care at home.						
9. You felt you were ready to go home when released.						
10. How would you rate your overall experience?						

11. Did you have any pain while you were in the operating room:
NONE_____ MILD_____ MODERATE_____ SEVERE_____

12. Would you use our surgery center again or recommend our facility to others? YES ___ NO ___
If not, why not? _____

13. From the time you were told to arrive at the Center, did you stay in the waiting room:

Less than 30 minutes_____ More than 30 minutes _____

If you waited more than 30 minutes, were you informed of the reason: YES ___ NO___

14. What is the one thing we could have done to make your time with us better?
_____
_____

Name (Optional):_____ Date of Surgery _____

Would you like a response to your concerns? YES___ NO ___ Phone #_____

Please write any additional comments. Thank you.