

CLIENT SATISFACTION SURVEY

Patient Name Cook Carolyn Date 05/15/2018

We were privileged to participate in the care of the above client. We are interested in rendering quality care to our clients and would appreciate your input by answering the following questions. Your evaluation will allow us to be more responsive to future client/family needs.

1. What services(s) did you receive from the Agency?

- | | |
|--|--|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input checked="" type="checkbox"/> Home Health Aide | <input type="checkbox"/> Medical Social Worker |

2. Were you satisfied with the care you received?

Yes No If not, why? _____

3. Did you participate in your plan of care?

Yes No

4. Did you receive and understand your "Bill of Rights" including the toll free "Hotline" number that you could call if any problems were not resolved by the Agency?

Yes No

5. Did the staff visit as frequently as they stated they would when they started your services?

Yes No

6. Did you feel comfortable asking staff questions regarding your health?

Yes No

7. Did the staff person visit at a mutually agreeable time?

Yes No

8. If you had therapy, were exercise instructions given to you in a clear, written manner that you could easily understand?

Yes No N/A

9. Did you feel that you were discharged appropriately?

Yes No N/A (current patient)

10. Would you use the services of the Agency in the future?

Yes No If not, why? _____

Suggestions for improvement: Totally satisfied with all facets of
the relationship I have with Apicon —
and I appreciate them !!