



Compassionate Care of Shelby County, Inc.
Satisfaction Survey

Compassionate Care of Shelby County, Inc. is committed to provide you and your family with the highest quality services. To help us evaluate and improve our services, we would like you to complete this survey. The information you provide is confidential. Thank You!

Date: _____

PLEASE CHECK EACH RESPONSE:

	Does not Apply	Poor	Fair	Good	Excellent
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1. INTERACTION

- | | | | | | |
|-----------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Intake staff treated you courteously | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Visit was private with your health care provider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Staff helped you with your problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Confidentiality maintained | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Professionalism shown by staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Recommendations for improving the INTERACTION with CCSC Staff: _____

2. ACCESS

- | | | | | | |
|----------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Convenience and location of facility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hours of operation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Length of time between making an appointment and seeing the health care staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Time spent in waiting area for your scheduled appointment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Recommendations for improving the ACCESS to CCSC: _____

3. EXAM ROOMS & FACILITY

- | | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Attractiveness of the facility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cleanliness of facility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Noise level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. OVERALL

- | | | | | | |
|---------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Overall, how would you rate the quality of service you received? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your willingness to return for treatment and/or follow-up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. Would you recommend the services of CCSC to others? Yes No

6. Is there anything that would keep you from returning for services? _____

7. We welcome any additional thoughts, suggestions and/or recommendations you may have concerning our organization: _____

DEMOGRAPHIC DATA

The following questions are asked strictly for the purpose of demographic or statistical information. Your responses will not be identified.

1. Your sex: Female Male

2. Your ethnic background: African American Caucasian Hispanic
Asian Native American Other

3. Age: 1-17 18-29 30-49 50-64 65+

4. Person filling out survey: Patient Family member Staff person
Other (specify) _____

5. CCSC would like to contact or remind you of your scheduled appointment. Please circle item or items below where we can leave a message:
Telephone Answering Service Machine Pager
Voice Mail None of the above Other: _____

6. Would you like someone to call you regarding your comments? Yes No

FOR FOLLOW-UP CALL, PLEASE PROVIDE US WITH YOUR NAME, ADDRESS AND TELEPHONE NUMBER IN THE SPACE BELOW.

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

THANK YOU AND GOD BLESS!