

Patient Experience

We are interested in your experience with the healthcare services you have received. We would greatly appreciate your assistance, as your responses will be used to help review how healthcare services are delivered, and to help improve services where necessary.

This survey takes an average of 10 minutes to complete.

All responses will be strictly confidential. You are not asked for any information that could be used to identify you.

For each question, please select the appropriate box.

1.	Were you able to get an appointment time that suited you?	Please select one box	
		Yes, definitely	<input type="checkbox"/>
		Yes, to some extent	<input type="checkbox"/>
		No	<input type="checkbox"/>
		Don't know/can't remember	<input type="checkbox"/>

2.	Did the health professionals explain things in a way you could understand?	Please select one box	
		Yes, always	<input type="checkbox"/>
		Yes, sometimes	<input type="checkbox"/>
		No	<input type="checkbox"/>

3.	I was involved as much as I wanted in making decisions about my treatment and care	Please select one box	
		Always	<input type="checkbox"/>
		Mostly	<input type="checkbox"/>
		Sometimes	<input type="checkbox"/>
		Rarely	<input type="checkbox"/>
		Never	<input type="checkbox"/>

4.	My views and concerns were listened to	Please select one box	
		Always	<input type="checkbox"/>
		Mostly	<input type="checkbox"/>
		Sometimes	<input type="checkbox"/>
		Rarely	<input type="checkbox"/>
		Never	<input type="checkbox"/>
		Didn't apply	<input type="checkbox"/>

5.	Do you have a treatment plan for your condition(s) that you can carry out in your daily life?	Please select one box	
		Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		Not sure	<input type="checkbox"/>

6.	Have you been given enough information about how to manage your care at home?	Please select one box	
		Yes, completely	<input type="checkbox"/>
		Yes, to some extent	<input type="checkbox"/>
		No, I was not given enough	<input type="checkbox"/>
		I did not need this type of information	<input type="checkbox"/>

7.	Did you feel you were treated with respect and dignity while you were at the clinic or service?	Please select one box	
		Yes, always	<input type="checkbox"/>
		Yes, sometimes	<input type="checkbox"/>
		No	<input type="checkbox"/>

8.	Overall, how would you rate the care you received in the clinic/or service?	Please select one box	
		Very good	<input type="checkbox"/>
		Good	<input type="checkbox"/>
		Neither good nor poor	<input type="checkbox"/>
		Poor	<input type="checkbox"/>
		Very poor	<input type="checkbox"/>

9.	Which language do you mainly speak at home?	Please select one box	
		English	<input type="checkbox"/>
		A language other than English	<input type="checkbox"/>

Thank you for taking the time to provide feedback about your care. The information we receive will be used to continue to improve our services