CLIENT LOGO

OUTPATIENT BEHAVIORAL HEALTH SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Referred through an Emergency Department ..... ○ Yes ○ No
2. Referred by your physician ..... ○ Yes ○ No
3. Informed of patients' rights including confidentiality ..... ○ Yes ○ No
4. Patient's first use of this outpatient treatment program ..... ○ Yes ○ No
5. How many visits have you had for this treatment program? ..... ☐☐
6. Date this treatment began:

   ☐☐ / ☐☐ / ☐☐☐☐
   month / day / year
7. Date this treatment ended:

   ☐☐ / ☐☐ / ☐☐☐☐
   month / day / year
8. Patient's sex ..... ○ Male ○ Female
9. Patient's age ..... ☐☐☐

INSTRUCTIONS: Please rate the services you received from our facility. <u>Select the response</u> that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of getting an appointment	○	○	○	○	○
2. Convenience of available appointment times	○	○	○	○	○

Comments (describe good or bad experience): _____

TREATMENT AREA

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Cleanliness of the treatment area	○	○	○	○	○
2. Privacy of the treatment area	○	○	○	○	○
3. Comfort level in and around the treatment area	○	○	○	○	○

Comments (describe good or bad experience): _____

CARE PROVIDER

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy and respect of the care provider	○	○	○	○	○
2. Helpfulness of time spent with the care provider	○	○	○	○	○

YOUR CARE PROVIDER IS THE PERSON WHO ADDRESSES YOUR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CARE PROVIDER MAY BE A PSYCHIATRIST, MEDICAL DOCTOR, PHYSICIAN ASSISTANT (PA), OR NURSE PRACTITIONER (NP). <u>PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.</u>

this section continued on next page...

CARE PROVIDER (...continued)

	very poor 1	poor 2	fair 3	good 4	very good 5
3. How well the care provider informed you about your medication (if you were prescribed medication)	○	○	○	○	○

Comments (describe good or bad experience):

PRIMARY THERAPIST

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Your trust in the skill of the therapist	○	○	○	○	○
2. Therapist's concern for your questions and worries	○	○	○	○	○
3. How well the therapist understood you and your needs	○	○	○	○	○
4. How well the therapist kept you informed about your treatment	○	○	○	○	○

Comments (describe good or bad experience):

YOUR CARE

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff's concern for your privacy	○	○	○	○	○
2. How well the staff addressed your emotional needs	○	○	○	○	○
3. Staff's response to concerns/complaints made during your care	○	○	○	○	○
4. Staff's efforts to include you in decisions about your care	○	○	○	○	○

Comments (describe good or bad experience):

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Overall rating of care given at this center	○	○	○	○	○
3. Likelihood of your recommending this center to others	○	○	○	○	○

Comments (describe good or bad experience):

Patient's Name: (optional)

Telephone Number: (optional)

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