

PATIENT EXPERIENCE SURVEY

Thank you for participating in our Family Health Team's Patient Experience Survey! This survey focuses on your experience with us in the last 12 months. Please note that your feedback is strictly confidential.

YOUR APPOINTMENT

1. Thinking about your most recent visit, on a scale of poor to excellent, how would you rate the following?

	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
The length of time it took between making your appointment and the visit you just had	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your overall experience with our reception staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Thinking about your experiences over the last year or so, were there any barriers in accessing our services?

- No
 Somewhat
 Yes
 Please explain: _____

3. The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see a doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?

- Same Day
 Next Day
 2-19 days (enter # of days below)
 20 or more days
 Not applicable (don't know/refused)

4. Did you feel that your health concern needed to be addressed within the same day or next day?

- Yes
 No
 Don't Know

5. When you see your doctor or nurse practitioner, how often do they or someone else in the office...

	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Give you an opportunity to ask questions about recommended treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involve you as much as you want to in decisions about your care and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spend enough time with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**VISITING THE EMERGENCY DEPARTMENT**

6. Have you been to an emergency department because you were sick or for a health-related problem?
- Yes
- No (*Skip Next Question*)
7. Which of the following was the MAIN reason you went to emergency rather than to your doctor or nurse practitioner? Select only answer.
- It was an emergency
- Your doctor or nurse practitioner was not available
- You could not get an appointment with your doctor or nurse practitioner
- It was faster to go to the emergency
- The emergency was closer
- Your doctor or nurse practitioner advised you to go emergency
- Your doctor works out of the emergency
- Don't know/Refused
- Other, please specify: _____

YOUR OVERALL EXPERIENCE

8. If you would like to provide additional feedback, please use the space below:

9. Overall, how would you rate your experience at the Kapuskasing and Area Family Health Team?
- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | <input type="checkbox"/> Very Poor |
| <input type="checkbox"/> Fair | |

Please submit by email to ljean@kapfht.ca
or by mail/in-person to 142 C Progress Crescent, Kapuskasing, Ontario P5N 3H6

Thank you for taking the time to complete our survey!