PATIENT SATISFACTION SURVEY: REFERRAL PROCESS – COORDINATION OF CARE

Regarding your referral to: _____

We thank you in advance for completing this survey. We are striving to improve your experience when you are referred to a specialist, and your feedback and comments will help. Please fill out this survey and return it in the enclosed envelope **after** you have seen the specialist.

Instructions: Please rate the service you received by checking the box that best describes your experience.

	Very Poor	Poor	Fair	Good	Very Good
Ability to get an appointment when you wanted (day of the week, time of day, etc.).	☐	☐	☐	☐	☐
Length of time until you were notified of your appointment.	☐	☐	☐	☐	☐
Length of time until you saw the specialist (appointment date).	☐	☐	☐	☐	☐
Instructions provided by our staff (directions, appointment time, special preparations, etc.)	☐	☐	☐	☐	☐
Overall rating of care received from specialist.	☐	☐	☐	☐	☐

Other comments:	
Your name (optional):	Phone number (optional):