**Hospital Client Satisfaction Questionnaire Form**

**Patient Information**

* **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ☐ Male ☐ Female**
* **Hospital ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Quality Evaluation**

| **Criteria** | **Excellent ☐** | **Good ☐** | **Fair ☐** | **Poor ☐** |
| --- | --- | --- | --- | --- |
| **Cleanliness of Facility** |  |  |  |  |
| **Courtesy of Medical Staff** |  |  |  |  |
| **Explanation of Treatment** |  |  |  |  |
| **Comfort During Stay** |  |  |  |  |
| **Wait Time** |  |  |  |  |
| **Overall Experience** |  |  |  |  |

**Open-Ended Questions**

* **What did you appreciate most during your visit?**
* **What could we improve?**

**Patient Consent
I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to the use of my feedback for improving hospital services.**

**Signature**

* **Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Hospital Use Only**

| **Verified By** | **Date** | **Comments** |
| --- | --- | --- |
|  |  |  |
|  |  |  |