**Patient Feedback Form for Hospital**

**Patient Information**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Department Visited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Number (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Feedback on Hospital Services**

1. **Overall experience at the hospital:**
   * **( ) Excellent**
   * **( ) Good**
   * **( ) Average**
   * **( ) Poor**
2. **Cleanliness and hygiene of the hospital:**
   * **( ) Excellent**
   * **( ) Good**
   * **( ) Average**
   * **( ) Poor**
3. **Waiting time for services:**
   * **( ) Less than 15 mins**
   * **( ) 15-30 mins**
   * **( ) 30-45 mins**
   * **( ) More than 45 mins**

**Additional Comments**

* **Please provide specific feedback on how we can improve our services:**

| **Service Area** | **Rating (1-5)** | **Comments** | **Suggestions** |
| --- | --- | --- | --- |
| **Reception** |  |  |  |
| **Nursing Care** |  |  |  |
| **Cleanliness** |  |  |  |
| **Doctors** |  |  |  |