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			