**Standardized Patient Satisfaction Questionnaire Form**

**Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Department/Service Area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Standardized Evaluation Categories**

| **Evaluation Area** | **Excellent** | **Good** | **Satisfactory** | **Needs Improvement** |
| --- | --- | --- | --- | --- |
| **Ease of Scheduling Appointment** |  |  |  |  |
| **Wait Time Before Appointment** |  |  |  |  |
| **Explanation of Treatment** |  |  |  |  |
| **Courtesy of Reception Staff** |  |  |  |  |
| **Cleanliness of Facilities** |  |  |  |  |
| **Follow-up Instructions Provided** |  |  |  |  |
| **Communication Skills of Provider** |  |  |  |  |
| **Availability of Parking** |  |  |  |  |

**Special Notes**

* **Were you satisfied with your overall experience?  
  ☐ Yes ☐ No ☐ Partially**
* **Would you recommend our facility to others?  
  ☐ Yes ☐ No**

**Additional Feedback or Suggestions**