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