Baystate Rehabilitation Care
Satisfaction Survey

Please check appropriate service:
_____ Physical Therapy _____ Occupational Therapy _____ Speech Therapy _____ Audiology

Today's Date: ___/___/___ Clinician's name (optional):_____

YOUR OPINIONS ARE VERY IMPORTANT. THEY WILL HELP US PLAN FOR IMPROVING THE QUALITY OF OUR CARE. THANK YOU.
Please mark the box that best describes your experience with each of the items listed below.

Location: **Baystate Mary Lane Hospital**

How would you rate the following items?	***Excellent***	***Very Good***	***Good***	***Fair***	***Poor***
1. Courtesy and helpfulness of the front office staff?					
2. Your therapist's understanding and caring?					
3. Your participation in decisions about your plan of care?					
4. Being well informed of your progress?					
5. Quality of care provided by the therapist?					
6. Respect for your privacy?					
7. Feeling of safety in our facility during your treatment?					
8. Therapist's instructions and explanations?					
9. Improved ability to meet your personal goals?					
10. Overall satisfaction with our service?					
11. Likelihood of you recommending this clinic to friends and relatives?					
For office use only Totals					

12. If you did not mark excellent for an above question, could you explain how we could reach an excellent rating?

_____
_____
_____
_____

***OPTIONAL:** _____
(Name) (Address) (Phone)

Thank you for your help.