

**PATIENT PERCEPTION / SATISFACTION SURVEY**

**Iconic Healthcare Services, Corporation**

You have recently received services from **ICONIC HEALTHCARE SERVICES, CORPORATION**. We want to insure that we met your needs and provided quality care. You can help us by rating our service by responding to the following questions.

Please return this form to our agency.

Questions	Excellent	Good	Average	Fair	Poor	NA
1. Did nurse, therapist, and/or aide provide courteous service?	5	4	3	2	1	<input type="checkbox"/>
2. Did the staff explain the care being provided and ask your needs?	5	4	3	2	1	<input type="checkbox"/>
3. Do you feel staff members met your needs ?	5	4	3	2	1	<input type="checkbox"/>
4. Did the agency provide the service and care that you expected ?	5	4	3	2	1	<input type="checkbox"/>
5. Was the staff responsive to your pain and attempted to keep it at an acceptable level ?	5	4	3	2	1	<input type="checkbox"/>
Were you told when service changed or was going to end ?	5	4	3	2	1	<input type="checkbox"/>
7. Your overall rating of the agency was:	5	4	3	2	1	<input type="checkbox"/>
8. Would you recommend this agency to a friend or relative?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

In your opinion, how can the agency improve patient safety? 4/4

Comments: \_\_\_\_\_

Please complete this form so we can meet your needs in the future and if a problem exists, can correct it. We are dependent on your input.

Your signature is optional. If you do elect to sign the form, would you allow us to call you to clarify any questions ?

Yes  No

Thank you for completing this form.

Lee Watson

6-9-12

Signature (optional)

Date