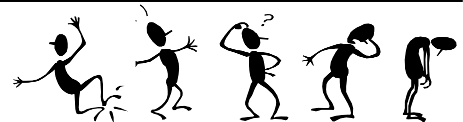
Capital Women's Health

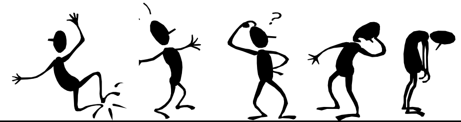
Patient Feedback Form

We would like to know how you feel about the services and care we provide so we can make sure we are meeting your needs. Your feedback is important to us and allows us to provide you with high quality care and continue to improve the care we deliver. All responses will be kept confidential and anonymous. Thank you for your time.

Which doctor did you see: ___ Dr Low
___ Dr Gailani
___ Dr Tan
___ Canberra Fetal Assessment Centre
___ Dr Angstmann
___ Dr Fitzgerald
___ Dr Perampalam



Please circle how well you think we are doing in the following areas:	Excellent 5	Good 4	OK 3	Fair 2	Poor 1
Ease of accessing care:					
Ability to get an appointment	5	4	3	2	1
Hours the practice is open	5	4	3	2	1
Convenience of our practice's location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Waiting times:					
Time spent in waiting room	5	4	3	2	1
Time in consulting room	5	4	3	2	1
Waiting for tests to be performed	5	4	3	2	1
Waiting for test results	5	4	3	2	1
Staff:					
Provider: **(Doctor/Sonographer/Midwife)**					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1
Nurses and Medical Assistants:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1



Please circle how well you think we are doing in the following areas:	Excellent 5	Good 4	OK 3	Fair 2	Poor 1
Reception staff:					
Presented a professional image					
Friendly, considerate, sensitive and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Facility:					
Was the practice comfortable and clean	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Were you able to find a parking space close by?	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Privacy	5	4	3	2	1
Confidentiality:					
Keeping my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1

What do you like best about our practice? ____

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What do you like least about our practice? _______________________________________

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How were you referred to Capital Women's Health? ________________________________

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Suggestions for improvement? ____

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Thank you for completing our Survey!