



PLEASE HELP US SERVE YOU EVEN BETTER!

At Riverview ASC, patient satisfaction is very important and we would like your help to identify areas that need improvement. Please take a few minutes to answer the following questions. After you have completed the questionnaire, please return to the address listed above.

Date of Surgery: _____

Surgeon's Name: _____

	Excellent	Very Good	Good	Fair	Poor
1. Adequacy of explanation of surgery procedures by staff	5	4	3	2	1
2. Adequacy of pre-admission instructions by staff	5	4	3	2	1
3. Level of staff friendliness, helpfulness, and courtesy	5	4	3	2	1
4. Degree to which staff paid attention to your needs, concerns, or discomfort	5	4	3	2	1
5. Level to which the staff met your pain needs	5	4	3	2	1
6. Performance of your Anesthesia Care Provider and their explanation of your received type of anesthesia	5	4	3	2	1
7. Explanation of post-operative instructions, diet, medications, activity, bandage changes, etc.	5	4	3	2	1
8. Length of time waiting	5	4	3	2	1
9. Overall rating of our facility	5	4	3	2	1
10. Likelihood to recommend Riverview ASC to family and friends	5	4	3	2	1

We welcome your comments and suggestions:

Thank you for your assistance and trusting Riverview ASC for your outpatient needs. If you would like us to contact you about your survey, please provide your name, phone number, and best time to call.

Name: _____ Phone: _____ Best time to call: _____