Dove Creek
COMMUNITY HEALTH CLINIC
Serving Families Since 1975
MEDICAL • DENTAL • BEHAVIORAL HEALTH

PO Box 576, 495 W 4th St., Dove Creek CO 81324
(970) 677-2291 • **Fax:** (970) 677-2540

2018 Patient Experience Survey (Medical)

We really value your opinion and your time. Please help us to make the Clinic better for you by completing this survey. You may use the back of this page if there is not enough room to explain items below.

1. Were you able to get an appointment as quickly as you felt necessary for your health condition? **YES / NO**
   If NO, would you help us improve by explaining? _____

2. How much delay did you experience between your appointment time and being taken to an exam room?
   NO DELAY / FAIRLY QUICK / NOTICEABLY LONG

3. Who was your health provider (MD, NP, PA, RN, Behavioral Health Counselor)? _____
   Do you feel the person spent adequate time with you. **YES/NO**
   Do you feel the person explained things in a way that you understood? **YES/NO**
   Overall, are you happy with care the person provided? **YES/NO**
   If NO to any of the above, please help us adjust by explaining. _____

4. If you have had testing done in previous visits, were you informed of results within a reasonable time (i.e., 10 days)?
   Lab **YES/NO** X-Ray **YES/NO** Other (please specify)_____ **YES/NO**

5. Specialist are doctors like surgeons, heart doctors, allergy doctors, skin doctors and other doctors who specialize in one area of health care. Does your clinic provider seem informed and up-to-date about the care you received from the specialist? **NOT APPLICABLE** / **YES / NO**

6. Do you feel you have been treated today with respect for your concerns and interests by each person contributing to your care? **YES/NO**

7. Has anyone in the clinic discussed specific goals with you about your health? **YES/NO**

8. Overall, do you feel that all your health needs are currently being met by your clinic? **YES/NO**
   If not, could you help us adjust by explaining? _____

9. Considering everything, do you feel the fees are reasonable?
   Office Visit **YES/NO** Supplies **YES/NO** Medicine **YES/NO** Are you on sliding fees? **YES/NO**

10. How could we change our scheduling to better accommodate your needs? (circle all that apply)
    EXTENDED HOURS - EARLY MORNING / LATE EVENING / SATURDAYS **/ OTHER:**_____

11. How likely are you to recommend this clinic to your family and friends?
    WOULD NOT AT ALL / POSSIBLY / LIKELY / DEFINITELY

Please indicate any other comments to improve your satisfaction with care at the clinic. Use the back of this form if needed. _____

Name **(optional, but it will help us to address any concerns you might have.)** **YOUR AGE** **DATE**