

DEPARTMENT OF GENITO URINARY MEDICINE PATIENT SATISFACTION QUESTIONNAIRE

Please place *X* inside boxes to indicate your response

<p>Q1 Did you have a specific appointment time? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q2 Were you seen within 30 minutes of your appointment time? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q3 If you had no appointment, how long did you have to wait to be seen by a doctor or nurse?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">0 - 15 mins</td> <td style="width: 25%;"><input type="checkbox"/></td> <td style="width: 25%;">15 - 30 mins</td> <td style="width: 25%;"><input type="checkbox"/></td> </tr> <tr> <td>30 - 60 mins</td> <td><input type="checkbox"/></td> <td>1 - 2 hours</td> <td><input type="checkbox"/></td> </tr> <tr> <td>more than 2 hours</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> <p>Q4 Did you find the staff pleasant and helpful?</p> <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">N/A</th> </tr> </thead> <tbody> <tr> <td>Receptionist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Doctor</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Nurse</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Health Adviser</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Social Worker</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Q5 Did the doctor introduce himself/herself? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q6 Did the doctor make you feel at ease? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q7 Did the doctor explain what would happen? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q8 Did the nurse introduce himself/herself? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q9 Did the nurse make you feel at ease? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q10 Did the nurse explain what would happen? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	0 - 15 mins	<input type="checkbox"/>	15 - 30 mins	<input type="checkbox"/>	30 - 60 mins	<input type="checkbox"/>	1 - 2 hours	<input type="checkbox"/>	more than 2 hours	<input type="checkbox"/>				Yes	No	N/A	Receptionist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Adviser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Q11 Were you happy that your privacy and dignity were respected? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Q12 If you got results today how long did you wait after the tests were done?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">0 - 15 mins</td> <td style="width: 25%;"><input type="checkbox"/></td> <td style="width: 25%;">15 - 30 mins</td> <td style="width: 25%;"><input type="checkbox"/></td> </tr> <tr> <td>30 - 60 mins</td> <td><input type="checkbox"/></td> <td>1 - 2 hours</td> <td><input type="checkbox"/></td> </tr> </table> <p>Q13 Did you receive enough information about :</p> <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Tests</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Results</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Condition</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Treatment</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Q14 Were you satisfied with :</p> <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Confidentiality</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Clinic Times</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Waiting area</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sign posting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Q15 If you requested to see a specific person did you see them? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>COMMENTS :</p> <p>.....</p> <p>.....</p> <p>.....</p>	0 - 15 mins	<input type="checkbox"/>	15 - 30 mins	<input type="checkbox"/>	30 - 60 mins	<input type="checkbox"/>	1 - 2 hours	<input type="checkbox"/>		Yes	No	Tests	<input type="checkbox"/>	<input type="checkbox"/>	Results	<input type="checkbox"/>	<input type="checkbox"/>	Condition	<input type="checkbox"/>	<input type="checkbox"/>	Treatment	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	Confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	Clinic Times	<input type="checkbox"/>	<input type="checkbox"/>	Waiting area	<input type="checkbox"/>	<input type="checkbox"/>	Sign posting	<input type="checkbox"/>	<input type="checkbox"/>
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THANK YOU for completing this questionnaire.
Please ensure form is collected when completed.