easterseals
Capital Region & Eastern Connecticut

Patient Satisfaction Survey

Please complete the following survey to provide us with information so that we may continue to improve our life-changing services. Thank you very much for your assistance. It has been our pleasure serving you.

Form completed by:	Patient _____	Family _____	Other _____

Reason for admission (diagnosis): _____

Services received: PT ____ OT ____ SLP ____ Social Work ____ Neuropsychology ____

Admission Date: _____

Discharge Date: _____

	Please check the box that best describes your experience				
	4	**3**	**2**	**1**	**N/A**
	Excellent	**Good**	**Fair**	**Poor**	
1. Promptness of admission following my referral to the Center.					
2. Consideration of my needs when scheduling appointments.					
3. The opportunity to participate in the development of my treatment plan.					
4. Appropriateness of appointment frequency and duration.					
5. Consideration of my goals for therapy.					
6. Promptness with addressing issues discussed with the Center or therapist.					
7. The opportunity to participate in the discharge planning process.					
8. Satisfaction with the outcome of my treatment.					
9. Accuracy of program information as presented by staff, print, website.					
10. Overall impressions of the Center.					

How likely are you to refer a friend or family member to the Center? _____

Additional Comments: _____

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Please return by mail to 100 Deerfield Rd, Windsor, CT 06095 or by fax to 860-748-4432.