



Holtsclaw Medical Centre  
4666 West Jefferson Blvd Suite 140  
Fort Wayne, IN 46804  
260-432-0100

## How Are We Doing?

Please take a few minutes to fill out this survey on the timeliness and quality of the service you received today. Holtsclaw Medical Centre welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

### General Patient Information

**In general, what is the quality of your health?**

- Outstanding     Good     Some chronic issues     Poor

**How would you rate our concern for your privacy?**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

**How often have you visited Holtsclaw Medical Centre within the past year?**

- First Visit     2-5 Visits     More than 6

### Scheduling Your Appointment

**Did you schedule an appointment by phone or did you drop in?**

- Scheduled by phone     Dropped in

**If you scheduled an appointment, did you have to wait longer than expected to get scheduled?**

- Yes     No

**How easy was it to make an appointment by telephone?**

- Very easy                         Very difficult

**How long did you wait to speak to a scheduling staff member?**

- 0 to 2 minutes       3 to 5 minutes       5 to 7 minutes       Longer

**Was the person who scheduled your appointment courteous and helpful?**

- 
- Very courteous      Rude

**If you were seeking a referral to a specialist, was your request handled in a timely manner?**

- Yes       No

**Day of Your Appointment**

**How would you rate the courtesy of the staff at the reception desk?**

- 
- Very courteous      Rude

**How long did you wait in the reception area beyond your scheduled appointment time?**

- 0 to 5 minutes       5 to 20 minutes       20 to 40 minutes       Other \_\_\_\_\_

**How long did you wait in the exam room before the physician appeared?**

- 0 to 5 minutes       5 to 20 minutes       20 to 40 minutes       Other \_\_\_\_\_

**Which department(s) did you visit during your appointment?**

- General Practitioner
- Walk-in/Urgent Care
- Pediatrics
- Women's Health
- Counseling & Therapy

## The Nursing Staff

**How would you rate the competence of the nurse who helped you?**

Outstanding    Good    Adequate    Needs improvement    Poor    N/A

**How would characterize the concern that the nurse showed for your problem?**

Outstanding    Good    Adequate    Needs improvement    Poor    N/A

**Did the nurse respond to your requests within a reasonable period?**

Yes    No

## The Doctor

**Were you able to see the doctor of your choice?**

Yes    No    N/A

**Did you feel that your doctor spent an adequate amount of time with you?**

Yes    No    N/A

**Mark the boxes that characterize the demeanor of your doctor:**

Attentive    Concerned    Friendly    Distracted    Rushed    Inconsiderate

**How would you rate the competence of your doctor?**

Outstanding    Good    Adequate    Needs improvement    Poor    N/A

**Did you feel that your doctor's examination was thorough?**

- Yes       No       N/A

**Please rate the clarity of the doctor's explanation of your condition and treatment options:**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

**How well did your doctor include you in healthcare decisions?**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

**Were your questions answered to your satisfaction?**

- Yes       No       N/A

**Would you recommend this facility and its staff to your family and friends?**

- Yes       No       N/A

## The Lab Staff

**How would you rate the professionalism and competence of the person who took your blood and worked on your lab exam?**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

**If you received a lab exam, please indicate the type(s) of lab exam you received:**

- Blood test     Breast exam     CT scan     MRI     X-ray     Other \_\_\_\_\_

**If you received a lab exam, was the service prompt, comfortable, and courteous?**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

## Additional Feedback

**Please list any areas in which our service could be improved.**

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**Please share any additional comments.**

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## Personal Information

**Providing the following information is optional.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

**Would you like someone to contact you regarding your responses on this survey?**

Yes No

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.