PATIENT SATISFACTION

Having had your surgery at the Elective Surgery Centre we are very keen to know how you experiences the care provided by our team. We are always looking at ways to improve ourselves and with your help we can be the best we can. If you could please take a few minutes and provide us with your thoughts that would be very much appreciated.

	YOUR RIGHTS AS A PATIENT	YES	NO
1	Do you feel that you were treated with respect during your stay with us?		
2	Do you feel that your right to dignity and independence were respected by our team?		
3	Do you feel that our team communicated with you effectively?		
4	Did you feel fully informed throughout your journey with us?		
5	Do you feel that you were given the opportunity to make informed choices and give informed consent to treatment?		
6	Did you feel supported by our team?		

THE WDHB VALUES – How we aim to be with patients and each other every day	YES	NO
"Everyone Matters" Were you able to observe through the actions and behaviour from our team that everyone, including patients, clients, family members and staff matters?		
"With Compassion" Were you able to observe through the actions and behaviour from our team that we strive to do everything to relieve suffering and promote wellness?		
"Better, Best, Brilliant" Did you observe efficient, organised and safe practice from our team during your stay?		
"Connected" Did you observe teamwork/connectivity between patients, staff and families during your stay with us?		

Comments

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Please turn to page 2 of this form should you wish to register a Compliment or Complaint about the care received while at the Elective Surgery Centre

COMPLIMENTS or COMPLAINTS

The Elective Surgery Centre is committed to providing quality health care services to its patients. We welcome and need your feedback to assist us in doing this.

Compliments are sincerely appreciated:

Complaints give us the opportunity to continually assess and improve the services we provide:

Do you wish to be contacted about any of your comments: YES / NO

Patient Name: ____________________________________ Contact Number:_________________________________