Physician Satisfaction Survey

Name (optional) _____ Date _____

In order to provide quality care and service excellence, we are asking our valued customers for their assistance in completing this survey.

Please rate the following by utilizing a scale of 1 to 5, with 1 as the lowest mark of satisfaction and 5 as the highest

Ease of the referral process	1	2	3	4	5
Quality of care	1	2	3	4	5
Scope of services available	1	2	3	4	5
Problem/complaint resolution	1	2	3	4	5
Communication between your office and our staff	1	2	3	4	5
Overall satisfaction	1	2	3	4	5

Please share any suggestions or issues that would help us to improve our home health services that would meet your needs and those of your patients.

_____
_____
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_____
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_____

Thank you for taking time out of your busy schedule to provide this valuable input. Please return it in the enclosed envelope.

Respectfully,

Administrator