Call us at 1(800) 986-3004

QUALITY OUTCOMES

D&J Medical
ORTHOTICS PROSTHETICS COMPRESSION

Note: If you have a **Survey Code** from a printed survey that has been completed and returned, please enter the survey code at ~~www.surveycare.com~~ and submit the survey responses there.

Patient Identifier:

Service Date:

Location:

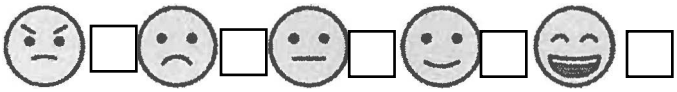
Care Provider:

Survey: PSS

*Means this is a required field

1. I could schedule an appointment that was convenient to me.
2. The receptionist treated me with respect.
3. The waiting area was comfortable.
4. I was seen in a timely manner.
5. The practitioner spent enough time with me.
6. The practitioner treated me with respect.
7. The practitioner answered all of my questions.

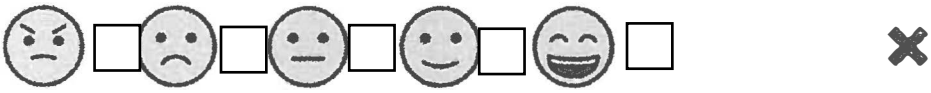
8. The practitioner listened to my concerns.



9. The practitioner involved me in my treatment plan.

10. The practitioner advised me on ways to avoid future problems.

11. The practitioner instructed me on how to take care of my skin in the affected area.



12. Overall, I am satisfied with the services I received from my practitioner.

13. How likely is it that you would recommend us to a friend or family member in need of similar services? (Not at all Likely = 0 Extremely Likely = 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

14. Additional comments:

15. Would you like us to contact you? If so, please enter your name and telephone number.