LYDDEN HILL MEDICAL & RESCUE SERVICES
PATIENT SATISFACTION SURVEY

FIRST NAME:		**LAST NAME:**	
DATE OF TREATMENT:		**EVENT:**	
PHONE NUMBER: (Optional)		**EMAIL: (Optional)**	

HOW WOULD YOU RATE THE FOLLOWING;

	VERY POOR	POOR	AVERAGE	GOOD	VERY GOOD
How involved did you feel in the decisions that were made about your treatment?					
Information about your care was clearly communicated to you					
Did you feel safe under our care?					
Were you treated with dignity and respect?					
How satisfied were you with the outcome of your treatment?					
Was the ambulance or medical centre clean?					
How would you rate your overall care from us?					

What could we have done better?	What did we do well?

Would you recommend our service to a family member or friend?	YES	NO

What else would you like to tell us about?

Once complete please return to a member of the Medical Team. Thank You!