

# East Coast Community Healthcare Inpatient Patient Satisfaction Questionnaire



Staff use only: Please enter your hospital name below.

We would like you to think about your recent experiences of our service/team and please tick the relevant box.

**How likely are you to recommend our services to your friends and family if they needed similar care or treatment?**

| Extremely Likely | Likely | Neither Likely or Unlikely | Unlikely | Not at all | Don't know |
|------------------|--------|----------------------------|----------|------------|------------|
|                  |        |                            |          |            |            |

**How satisfied are you with the service you have received**

| Very satisfied | Quite Satisfied | Neither satisfied nor dissatisfied | Quite dissatisfied | Very dissatisfied | Don't know |
|----------------|-----------------|------------------------------------|--------------------|-------------------|------------|
|                |                 |                                    |                    |                   |            |

**Can you please tell us why you gave these responses?**

Please tick this box if you are NOT happy for us to publish your comments (anonymously)

|   |                           |
|---|---------------------------|
| Male / Female <small>*delete as appropriate</small> | What age are you?         |
| What is your nationality?                           | Do you have a disability? |

### Service Evaluation Questions

**Please consider the following statements about your experience with the service(s) and mark which answer best matches your opinion.**

|  | Yes | No |
|--|-----|----|
| 1. The staff who assessed and treated me were FRIENDLY and HELPFUL   |     |    |
| 2. The length of my STAY in hospital was adequate  |     |    |
| 3. The INFORMATION I was given was easy to understand  |     |    |
| 4. I was involved in DECISIONS about my care   |     |    |
| 5. I was treated with DIGNITY and RESPECT  |     |    |
| 6. I feel that there has been an IMPROVEMENT and that I can better UNDERSTAND, MANAGE and MAINTAIN my own health |     |    |

Please provide your name and contact details if you wish us to follow up on your comments.

Name:

Contact Details:

Please tick this box if you are a Carer/Relative completing this form **on behalf of the patient**

# Friends and Family Test

## Patient feedback form



We are always striving to improve the services provided to our patients.

We would very much appreciate your feedback as a patient so we can continue to improve our services

Please would you take the time to complete the questions on the back of this form, moisten the edges, fold and either hand to a staff member or post.

No stamp needed.

Thank you

Please moisten gummed edges on reverse and fold here



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