

MEDICAL STAFF QUESTIONNAIRE RADIOLOGY CLINICS

This questionnaire is designed to assess the quality of radiology services provided to you. We could appreciate your comments, both positive and negative, which might help us in our continuing efforts to assure the quality of diagnostic services. Your signature is optional.

For the following questions, please indicate your degree of satisfaction by circling the appropriate number.

LEAST
SATISFIED

MOST
SATISFIED

	1 Very Dissatisfied	2 Somewhat Dissatisfied	3 Somewhat Satisfied	4 Very Satisfied	5 No Opinion
1. CLERICAL SERVICES					
A. Transcription of reports	1	2	3	4	5
B. Availability/timeliness of reports	1	2	3	4	5
C. Procedure scheduling	1	2	3	4	5
D. Cooperation with your office staff	1	2	3	4	5
E. Interaction with patients	1	2	3	4	5
F. Phone "hospitality"	1	2	3	4	5
G. Overall satisfaction with telephone reporting service	1	2	3	4	5

Comments: _____

2. TECHNOLOGISTS					
A. Quality of images	1	2	3	4	5
B. Cooperation with referring physicians	1	2	3	4	5
C. Interaction with patients	1	2	3	4	5
D. Cooperation with other clinics or offices	1	2	3	4	5
E. Timeliness in completion of exams	1	2	3	4	5

Comments: _____

3. OVERALL SERVICES					
A. Availability of films	1	2	3	4	5
B. Staffing	1	2	3	4	5
C. Patient wait time	1	2	3	4	5
D. Response to your complaints (If no complaints, circle 5)	1	2	3	4	5
E. Frequency of patient complaints	1	2	3	4	5
F. Billing explanations	1	2	3	4	5
G. Film loan policies	1	2	3	4	5
H. Copy film policies	1	2	3	4	5

Comments: _____

PLEASE TURN OVER

	LEAST SATISFIED			MOST SATISFIED	
	1 Very Dissatisfied	2 Somewhat Dissatisfied	3 Somewhat Satisfied	4 Very Satisfied	5 No Opinion
4. RADIOLOGISTS					
A. Quality/accuracy of reports	1	2	3	4	5
B. Days/hours of radiologist coverage	1	2	3	4	5
C. Availability for consultation	1	2	3	4	5
D. Cooperation with medical staff	1	2	3	4	5
E. Interaction with patients	1	2	3	4	5

Comments: _____

5. PHYSICAL FACILITIES					
A. Ease of access for patients	1	2	3	4	5
B. Proximity to emergency services	1	2	3	4	5
C. Cleanliness	1	2	3	4	5
D. Atmosphere	1	2	3	4	5
E. Decor	1	2	3	4	5
F. Parking	1	2	3	4	5

Comments: _____

6. PLEASE INDICATE YOUR MEDICAL/SURGICAL SPECIALTY:

PLEASE CHECK:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Dental Medicine | <input type="checkbox"/> Neurology | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Oncology | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Orthopedics | |

Thank you very much for your help in our process of improving our department.