

Patient Feedback Form

What type of comment would you like to send?

- Compliment
- Criticism
- Complaint
- Suggestion

Please write any comments or suggestions. We welcome all feedback:

Please indicate whether you are a:

- Patient
- Family member of a patient
- Escort

At which location of did you receive treatment?

- General Campus (The Ottawa Hospital, CHEO, Cancer Centre)
- Civic Campus
- Riverside Campus

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- Cancer Centre
- Riverside Campus
- Not sure / Can't remember

Is there anything our service can do to improve the care and services for you?

- No, I'm satisfied with everything
- Yes, some things can be improved: (please specify)

Patient Feedback Form

In the last 12 months, was it always easy to see a specialist up North when you felt you needed one?

- Yes
- No
- Not applicable

How long you waited to get an appointment?

- Excellent
- Good
- Very Good
- Fair
- Poor

How convenient was the location of the Ottawa Health Services Network Inc. office.

- Excellent
- Good
- Very Good
- Fair
- Poor

Ho was getting through to the office by phone/ pager?

- Excellent
- Good
- Very Good
- Fair
- Poor

Patient Feedback Form

How as the medical interpretation about your health problems and medical treatment?

- Excellent
- Good
- Very Good
- Fair
- Poor

Was information provided about other resources (reading materials, support groups).

- Excellent
- Good
- Very Good
- Fair
- Poor

How were the skills (thoroughness, carefulness, competence) of the Ottawa Health Services Network Inc. staff?

- Excellent
- Good
- Very Good
- Fair
- Poor

How as the personal manner (courtesy, respect, friendliness) of the Ottawa Health Services Network Inc. staff.

- Excellent
- Good
- Very Good
- Fair
- Poor

Patient Feedback Form

How do you feel about the quality of the medical visit overall?

- Excellent
- Good
- Very Good
- Fair
- Poor

In general, how would you rate your overall health?

- Excellent
- Good
- Very Good
- Fair
- Poor

What is your age?

- Under 25 years
- 25 - 44 years
- 45 - 64 years
- 65 years or older

Are you male or female?

- Male
- Female

Dates of Your Hospital Visit: (exact dates, if possible)

| Entered our system on: | | | Discharged from system on: | | |
|------------------------|----|------|----------------------------|----|------|
| | | | | | |
| dd | mm | yyyy | dd | mm | yyyy |

Ottawa Health Services Network Inc.
120-1929 Russell Road
Ottawa Ontario
K1G 4G3

Patient Feedback Form

How do you rate the overall quality of care that you received from The Ottawa Health Services Network Inc.?

- Excellent
- Very Good
- Good
- Fair
- Poor
- N/A

How well did The Ottawa Health Services Network Inc. meet your needs as a patient?

- Excellent
- Very Good
- Good
- Fair
- Poor
- N/A

If you wish to discuss your comments with a member of our hospital staff, or to receive a personal reply, please tell us who you are:

My Name: (optional)

My E-Mail Address: (optional)

My Telephone Number: (optional)