**SSRG – Client Satisfaction Survey Form**

**CLIENT DETAILS:**

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| Surname: |  | Date: |  |
| Given Names: |  | Contact Phone: |  |
| Email: |  |

**SURVEY QUESTIONS:**

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| **The SSRG Staff are courteous?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **I received clear information from the staff?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| --- |
| **The staff are knowledgeable?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **Appointments are available in a reasonable time frame?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **Appointment times are convenient?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **The clinicians met my needs?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **Patients are the top priority at SSRG?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **I would return to SSRG for additional care if required?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| **I would recommend SSRG to a family member or friend?** |
| StronglyDisagree | ⬜ | ModeratelyDisagree | ⬜ | SlightlyDisagree | ⬜ | N/A | ⬜ | SlightlyAgree | ⬜ | ModeratelyAgree | ⬜ | StronglyAgree | ⬜ |

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| --- | --- | --- | --- | --- |
| **Are there any aspects of our care which we could improve?** | **Yes** | ⬜ | **No** | ⬜ |
| **Additional Comments:** |
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| --- | --- | --- | --- | --- |
| **Do you have any further feedback for us?** | **Yes** | ⬜ | **No** | ⬜ |
| **Additional Comments:** |
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| For Internal Use Only |
| Date of Survey: |  | Coreplus Client Reference No.: |  |
| Allocated Clinician Name: |  | Details Entered (Date & Initial): |  |