

UW Medicine

HARBORVIEW MEDICAL CENTER

12/4/2024

Rate your visit at: HMC SENIOR CARE CLINIC

Dear Jeanne Hoffman,

At Harborview Medical Center, we are dedicated to providing high quality health care in a caring, compassionate and comfortable environment. To accomplish this, we depend on our patients and their families to tell us what we do well and what we could do better.

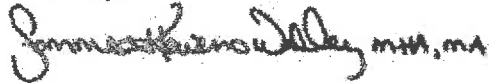
Feedback from our patients and their families is very important to us and is used regularly to improve the patient experience in our clinics. We'd like to ask that you please take a few minutes to complete the enclosed survey and return it in the postage-paid envelope.

Feel free to express your opinions. Your response is confidential, and whether you choose to fill out the survey or not, UW Medicine will continue to provide you with the best care possible.

Your comments will be reviewed and may be shared to recognize our care teams and/or to help improve our care and service.

Thank you, and please accept our best wishes for your good health.

Sincerely,



Sommer Kleweno-Walley, MHA, MA, CCC-SLP
Chief Executive Officer



MEDICAL PRACTICE SURVEY

Please rate your visit at: HMC SENIOR CARE CLINIC
With: Reema Navalurkar MD
On: 12/03/2024

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Was this your first visit here? Yes No
2. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room?

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 minutes
3. How many **minutes** did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife?

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 minutes

INSTRUCTIONS: Please rate the services you received from our practice. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
 Example: ●

ACCESS very poor poor fair good very good 1 2 3 4 5

1. Ease of scheduling your appointment
2. Ease of contacting (e.g., email, phone, web portal) the clinic

MOVING THROUGH YOUR VISIT very poor poor fair good very good 1 2 3 4 5

1. Degree to which you were informed about any delays
2. Wait time at clinic (from arriving to leaving)

NURSE/ASSISTANT very poor poor fair good very good 1 2 3 4 5

1. How well the nurse/assistant listened to you
2. Concern the nurse/assistant showed for your problem
3. Friendliness/courtesy of the nurse/assistant
4. Degree to which nurse/assistant talked with you using words you could understand
5. Instructions the nurse gave you about follow-up care (if any)



continued...

	very poor	poor	fair	good	very good
CARE PROVIDER	1	2	3	4	5

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Concern the care provider showed for your questions or worries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Explanations the care provider gave you about your problem or condition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Care provider's efforts to include you in decisions about your care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Likelihood of your recommending this care provider to others | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

	very poor	poor	fair	good	very good
PERSONAL ISSUES	1	2	3	4	5

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Our concern for your privacy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. How well the staff protected your safety (by washing hands, wearing ID, etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Our sensitivity to your needs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

	very poor	poor	fair	good	very good
OVERALL ASSESSMENT	1	2	3	4	5

- | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the staff worked together to care for you | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Likelihood of your recommending our practice to others | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

What is one thing we could improve to make your experience better in the future?

Thinking about this visit, are there any team members you would like to recognize? How did they stand out?

Patient's Name: (optional) _____
 Telephone Number: (optional) _____

