

Patient Evaluation Form: We want to hear your feedback!

Name (optional): _____ Date: _____

1. My appointment was scheduled as (check one): _____ Nuclear Stress Test _____ Office Visit
 _____ Echocardiogram _____ Vascular Study _____ Other

2. I received instructions about my test that I could understand: _____ Yes
 _____ No

3. The staff treated me with courtesy and respect: _____ Yes
 _____ No

4. The staff explained any delays in service: _____ Yes
 _____ No

5. The staff prepared me for possible side effects or discomforts related to my care: _____ Yes
 _____ No

6. My overall impression of the services I received was:
 _____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor

7. Comments or Suggestions:
