

Physician Evaluation Form: We want to hear your feedback!

Name (optional): _____ Date: _____

1. Are your patients scheduled in a timely manner? _____ Yes _____ No

Comments: _____

2. Do you receive test results promptly? _____ Yes _____ No

Comments: _____

3. Are your patients satisfied with our services? _____ Yes _____ No

Comments: _____

4. Do you find our staff helpful? _____ Yes _____ No

Comments: _____

5. Do you find the nuclear images helpful to the clinical management of your patients? _____ Yes _____ No

Comments: _____

6. What is your overall impression of our imaging services? _____ Yes _____ No

Comments: _____

Additional Comments: _____