

PATIENT SURVEY

LANTZ MEDICAL PROVIDER SATISFACTION MEASURE

Version 1 - 7/2007

Patient : _____ Date: _____ Completed by: _____

Notes: _____

STEP 1. Access, Delivery and Service

Yes No NA

- | | | | | |
|----|---|--------------------------|--------------------------|----------------------------|
| 1. | Did you receive and understand instructions on proper application and use of equipment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Do you feel confident to operate/use equipment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Have you been instructed to increase your ROM - Flex/Ext? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Have you increased? If so, what is your ROM - Flex/Ext | <input type="checkbox"/> | <input type="checkbox"/> | Flex: _____
Extn: _____ |
| 5. | Did you receive info on my Rights & Responsibilities, complaint process, billing, contact numbers and reasons to notify the equipment/supply company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Do you know who to call to report the equipment is ready for Pick-Up? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

STEP 2. Patient Status Outcomes

Yes No NA

Date Step 2 Completed

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| 1. | Was the Equipment delivered in a timely manner & was the equipment ready for use upon delivery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Were you satisfied with the equipment & Service? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Would you recommend our services to others? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | | <u>IMPROVED</u> | <u>SAME</u> | <u>WORSE</u> |
| | PAIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | RANGE OF MOTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | STIFFNESS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | SWELLING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Source of Information: _____ | | | |