



VALLEY MEDICAL CENTRE.
PATIENT PARTICIPATION SURVEY

Your chance to get involved and to make a difference!

Please tick either yes or no.

ON CONTACTING THE PRACTICE

When ringing for an appointment were you happy with the time you had to wait before the telephone was answered?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Were you happy with the appointment time you were given?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Was the person you spoke to polite and helpful?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Would you be happy for the receptionist to ask you some basic questions about your problems so we can direct your call to the correct person, i.e. doctor/nurse/healthcare assistant?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Were you aware of, or told about our online service for booking appointments and ordering repeat prescriptions?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Have you used our practice website?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

ON SEEING THE DOCTOR (If appropriate)

Were you happy with the amount of time you had with the GP?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Did you feel the GP understood and listened to you?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Do you feel the GP explained your problems or any treatment you need to your satisfaction?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Were you able to see the GP you wanted?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

ON SEEING THE NURSE OR HEALTH CARE ASSISTANT (If appropriate)

Were you happy with the amount of time you had?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Did you feel the nurse understood and listened to you?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Did you feel involved in managing your conditions?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Did you feel the nurse explained any treatment you needed?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

OVERALL

In general are you satisfied with the care you receive at the practice?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Would you recommend the surgery to someone who has just moved into the area?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Are you satisfied with the facilities at the practice? (E.g. the waiting room/toilets etc)

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If you have answered no to the questions above we would be grateful if you could provide further details in the comment box below.

COMMENTS;

**THANK YOU FOR TAKING THE TIME TO
COMPLETE OUR SURVEY!**