**PATIENT TELEHEALTH SURVEY**

**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.

If you cannot complete the entire survey at once, you may come back to it later. Your previous responses will be saved automatically and you will be able to continue where you left off. At any point during the survey, you can clear the entire survey and start over by clicking the "Clear Survey" button. When you have finished, please click the "Submit" button.

Please rate your visit on:

**ACCESS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  **Very poor** | **Poor** | **Fair** | **Good** | **Very good** |
|  |  |  |  |  |  |
|  | **1** | **2** | **3** | **4** | **5** |
|  |  |  |  |  |  |
| 1. Ease of arranging your video visit
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Ease of contacting us (e.g., email, phone, web portal)
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Ease of instruction on how to login to video visit
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |

**Comments** (describe good or bad experience): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARE PROVIDER**

DURING YOUR VIDEO 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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  **Very poor** | **Poor** | **Fair** | **Good** | **Very good** |
|  |  |  |  |  |  |
|  | **1** | **2** | **3** | **4** | **5** |
|  |  |  |  |  |  |
| 1. Concern the care provider showed for your questions or worries
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Explanations the care provider gave you about your problem or condition
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Care provider's efforts to include you in decisions about your care
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.)
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Likelihood of your recommending this care provider to others
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |

**Comments** (describe good or bad experience) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELEMEDICINE TECHNOLOGY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very poor** | **Poor** | **Fair** | **Good** | **Very good** |
|  |  |  |  |  |  |
|  | **1** | **2** | **3** | **4** | **5** |
|  |  |  |  |  |  |
| 1. Ease of logging into video visit
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Ease of talking with the care provider over the video connection
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. How well the video connection worked during your video visit
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. How well the audio connection worked during your video visit
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |

**Comments** (describe good or bad experience): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVERALL ASSESSMENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very poor** | **Poor** | **Fair** | **Good** | **Very good** |
|  |  |  |  |  |  |
|  | **1** | **2** | **3** | **4** | **5** |
|  |  |  |  |  |  |
| 1. How well the video visit staff (including the care provider) worked to care for you
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |
| 1. Likelihood of your recommending our video visit service to others
 | ⃝ | ⃝ | ⃝ | ⃝ | ⃝ |
|  |  |  |  |  |  |

**Comments** (describe good or bad experience): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Name: (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_