Inpatient Hospital Care Satisfaction Survey

Please complete this survey regarding your recent inpatient stay. Since this is a printed form, please write your answers clearly in the spaces provided.

General Information

Patient Name:

Admission Date:
MM/DD/YYYY

Discharge Date:
MM/DD/YYYY

Hospital Unit / Ward (e.g., ICU, Pediatrics, Maternity):

Quality of Care & Services

Please rate the following aspects of your stay on a scale of 1 to 10 (with 10 being the highest/best).

1. Cleanliness of your room and bathroom (Rating 1-10):

2. Friendliness and courtesy of the nursing staff (Rating 1-10):

3. Responsiveness of staff to call lights or requests (Rating 1-10):

4. How well doctors explained your treatments and conditions (Rating 1-10):

5. Quality and temperature of the meals provided (Rating 1-10):

6. Noise level in and around your room during the night (Rating 1-10, with 10 being very quiet):

7. Cleanliness and safety of the overall hospital environment (Rating 1-10):

8. Overall satisfaction with your hospital stay (Rating 1-10):

Feedback and Comments

What did our staff do exceptionally well during your stay?

What areas could we improve to make your stay more comfortable?

Thank you for taking the time to complete this survey. Your feedback helps us improve our care for future patients.