Patient Satisfaction Survey

St. Agnes Hospital Center for Sleep Disorders

Name: (Optional) ______________________________

Age: __________ ❑ Male ❑ Female Date of Service: ______________________________

QUESTION	Very Poor	Poor	Fair	Good	Very Good
1. Quality of services delivered by the Center for Sleep Disorders	1	2	3	4	5
2. Explanation of procedures and tests to me by the technician(s) before my sleep study	1	2	3	4	5
3. How reasonable was the length of time between having been referred by the sleep specialist and the actual scheduling of my sleep study?	1	2	3	4	5
4. Cleanliness and comfort of my room	1	2	3	4	5
5. Noise level of room so I was not disturbed	1	2	3	4	5
6. Helpful and courteous staff attentive to my needs and privacy	1	2	3	4	5
7. Skilled, knowledgeable and professional staff	1	2	3	4	5
8. Likelihood of recommending the Center for Sleep Disorders to a member of my family or a friend. If not, please share with us why	1	2	3	4	5

For statements marked three or lower, please provide a reason: ______________________________

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If you have any questions or concerns, please feel free to contact:

Danielle Reysen, Supervisor
Center for Sleep Disorders
St. Agnes Hospital
430 E. Division Street, Fond du Lac, WI
(920) 926-5020

Please return this survey by mail in the provided self-addressed envelope.

Thank You for Your Time.

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