



# Patient Feedback Survey – 3<sup>rd</sup> Edition Standards

**Practice Name:**

Dear Patients

It is important to this practice that we provide you, our patient, with a quality health service. Would you please take the time to fill out this anonymous survey about our practice so that we can identify areas in which we can better meet your needs?

This practice is undergoing accreditation with Australian General Practice Accreditation Limited (AGPAL), which includes patient feedback as part of its assessment. *AGPAL Accreditation* acknowledges the quality of a general practice.

**How would you rate your experience with this practice?  
number)**

**(Please circle appropriate**

#	Question	Unsatisfactory		Satisfactory		Above Average		Not Applicable
		←	→	←	→	←	→	
1	Availability of longer consultations	1	2	3	4	5	6	N/A
2	Having the urgency of my needs determined promptly when telephoning the practice	1	2	3	4	5	6	N/A
3	Obtaining information or advice about your health care by telephone or electronic means when a consultation is not necessary or practical	1	2	3	4	5	6	N/A
4	Arrangements for home and other visits both within and outside our normal opening hours	1	2	3	4	5	6	N/A
5	Arrangements for medical care outside our practices normal opening hours	1	2	3	4	5	6	N/A
6	Receiving sufficient information about the purpose, importance, benefits and risks of proposed investigations, referrals or treatments proposed by your GP for you to make an informed decision about your health	1	2	3	4	5	6	N/A
7	Being informed of costs before treatments, investigations or procedures performed by our practice in addition to the consultation cost	1	2	3	4	5	6	N/A
8	The advice provided by our practice that there may be potential for out of pocket expenses, if you are referred for investigation or for initial consultation to a specialist or allied health professional (e.g. that a gap payment may be necessary)	1	2	3	4	5	6	N/A
9	The doctors discuss health promotion or disease prevention with you	1	2	3	4	5	6	N/A
10	Are you able to see the doctor of your choice, if available	1	2	3	4	5	6	N/A
11	Do you feel that you are being treated respectfully by our doctors and staff	1	2	3	4	5	6	N/A

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12	The way in which the practice handles complaints and feedback that you may give to them	1	2	3	4	5	6	N/A
13	The practice obtains my permission <u>before</u> a consultation if there is ever a third person invited to be present in my consultation (e.g. a medical student, another staff member or a family member)	1	2	3	4	5	6	N/A
14	Ease of contacting the practice by telephone	1	2	3	4	5	6	N/A
15	Satisfaction with the facilities in the consulting area(s)	1	2	3	4	5	6	N/A
16	The way in which the practice makes adequate provisions for your privacy	1	2	3	4	5	6	N/A

## Other questions

17	Are you: <input type="checkbox"/> Male <input type="checkbox"/> Female
18	What is your age range? <input type="checkbox"/> 0 - 18 <input type="checkbox"/> 19 - 35 <input type="checkbox"/> 36 - 55 <input type="checkbox"/> 56 - 75 <input type="checkbox"/> 75 +
19	How long have you attended this practice? <input type="checkbox"/> Less than 2 years <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> Over 10 years
20	The doctor I usually see when I visit this practice is: _____

### Additional questions from the practice:

**Are there any other comments you would like to make about our practice, doctors and staff?**

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*Thank you for your participation Please fold and return this form to the person who gave it to you or put in the box provided*