

What did you think of this doctor?



	<i>Yes, definitely</i>	<i>Yes, to some extent</i>	<i>Not really</i>	<i>Definitely not</i>	<i>Does not apply</i>
Was the doctor polite and considerate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor listen to what you had to say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor give you enough opportunity to ask questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor answer all your questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor explain things in a way you could understand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you involved as much as you want to be in the decisions about your care and treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have confidence in your doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor respect your views?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the doctor examined you did he or she:					
a. Ask your permission?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Respect your privacy and dignity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
By the end of the consultation did you feel better able to understand and/or manage your condition and your care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, how satisfied were you with the doctor you saw?

- Very satisfied
 Fairly satisfied
 Not really satisfied
 Not at all satisfied

Please make any additional comments about the doctor in the space below

Please remember that this is just about the doctor you have seen today

About you -The patient

Your gender Male Female

Your age Under 16 16 - 30 31 - 45 46 - 60 61 - 75 76+

Who is filling out this form?

- You - the patient
 Family member or carer
 Facilitator
 Interpreter

Is English your first language? Yes No

