# Patient Survey Summary Form

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| **Date of Assessment:** |  |

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| **Trainee’s Name:** |  |

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| **Trainee’s GMC:** |  |

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| **Feedback given by:** |  |

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| --- | --- |
| **Number of responses received (minimum 20):** |  |

# Summary of comments received on attitude towards patients:

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**Summary of comments received on communication:**

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**Summary of comments received on whether patients felt better able to understand and/or manage their condition and care after the consultation:**

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**Summary of comments received on whether patients felt they were involved as much as they wanted to be in the decisions about their care and treatment:**

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**Trainee’s comments**

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**Agreed actions**

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Trainee’s signature…………………………………………………………………………………………………………………. Date…………………………………

Educational Supervisor signature…………………………………………………………………………………………… Date…………………………………