|  |
| --- |
| **What did you think of this doctor?** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Yes, definitely*** | ***Yes, to some extent*** | ***Not really*** | ***Definitely not*** | ***Does not apply*** |
| Did the doctor listen to what you had to say? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Did the doctor give you enough opportunity to ask questions? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Did the doctor answer all your questions? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Did the doctor explain things in a way you could understand? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Are you involved as much as you want to be in the decisions about your care and treatment? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Did you have confidence in your doctor? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| Did the doctor respect your views? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| If the doctor examined you did he or she:   1. Ask your permission | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| 1. Respect your privacy and dignity? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |
| By the end of the consultation did you feel better able to understand and/or manage your condition and your care? | 🗌 | 🗌 | 🗌 | 🗌 | 🗌 |

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

🗌 Very satisfied 🗌 Fairly satisfied 🗌 Not really satisfied 🗌 Not at all satisfied

**Please make 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