Outpatient Medical Center
Patient Visit Feedback Form

Date: ___/ ___/ _____ **Clinic Location:** ☐ Natchitoches ☐ Leesville ☐ Tallulah ☐ LP Vaughn School-Based

Services and Provider Seen Today (Select One Service and One Provider):

☐ **Medical:** ☐ Dr. Dametra Taylor, DNP ☐ Dr. Joyce Williams, DNP ☐ Dr. Donald Perry, MD
☐ Latonya Thomas, FNP ☐ Edith "Nikki" Lambert, FNP ☐ Mary Lancaster, FNP

☐ **Dental:** ☐ Dr. Bobby Jones, DDS ☐ Dr. Clifford Davis, DDS ☐ Kimberly Hoover, RDH

☐ **Behavioral Health:** ☐ Doris Kochinsky, LCSW ☐ Bobby Williams, LCSW

☐ **Nurse/Lab Only:** ☐ OMC Nurse ☐ LabCorp

Instructions: We want to know how we are doing. Your answers will help us improve our services.

1 - Poor	2 - Fair	3 - Satisfactory	4 - Good	5 - Excellent

#	Patient Satisfaction Question(s):	Score (Check One Per Question)				
		1	2	3	4	5
1	Please rate your overall experience today.					
2	Please rate your experience with the provider.					
3	Please rate your experience with the nursing staff.					
4	Please rate your experience with the registration staff.					
5	Please rate your wait time at the clinic.					
6	Please rate the cleanliness of the facilities.					
7	How well do the clinic's hours meet your needs?					
8	How easy was it to get all the care you needed?					
9	How easy was it for you to get to the clinic?					
10	How well do you feel the staff listened to your concerns?					
11	How well did the staff explain things in a way you could understand?					
12	How well did it seem the staff worked together to meet your needs?					
13	How likely are you to recommend us to family and friends?					

#	Risk Management and Quality Improvement Question(s):	Yes or No & Explain - Check One Per Question	
14	Did OMC staff provide you with follow-up care instructions and a follow-up appointment?	Yes ☐	No ☐
15	Are there any other services you would like to see OMC provide?	Yes ☐	No ☐
	If yes, select what service(s): ☐ Pharmacy ☐ Chiropractic ☐ Optometry ☐ Psychiatric ☐ Physical Therapy ☐ Pediatric ☐ Podiatry ☐ OBGYN ☐ Other: _____		
16	Did you experience any barriers in accessing care with us?	Yes ☐	No ☐
	If yes, what barriers did you encounter: ☐ Transportation ☐ Communication ☐ Financial Concerns ☐ Other: _____		
17	Did you see clinical staff (Nurses and Providers) use hand hygiene before and after your visit (this includes hand washing and/or the use of hand sanitizer)?	Yes ☐	No ☐
18	Did you notice any risk or safety concerns?	Yes ☐	No ☐
	If yes, please explain: _____		
19	Is there anything we can do to improve your experience? (Use the back if needed)	Yes ☐	No ☐
	If yes, please explain: _____		
20	Would you like a follow-up call in regard your experience with us today?	Yes ☐	No ☐
	If yes: Name: _____ **Best Contact #:** _____ **Best Time:** _____		