

REFERRING PHYSICIAN SATISFACTION SURVEY

QUALITY ASSURANCE

Please indicate the level of satisfaction that best reflects your experience with Columbia-Presbyterian Eastside Radiology by circling the appropriate number:

1 = very dissatisfied, 2 = dissatisfied, 3 = neutral, 4 = satisfied, 5 = very satisfied

CLERICAL SERVICES:

Courtesy and helpfulness of office staff	1	2	3	4	5
Calling to make an appointment	1	2	3	4	5
Phones answered promptly & hold time is minimal	1	2	3	4	5
Timely response to voice mail messages	1	2	3	4	5
Level of knowledge/courtesy of our front desk employees	1	2	3	4	5
Front desk interaction with your patients	1	2	3	4	5

FILMS & REPORTS:

Accuracy of reports	1	2	3	4	5
Receive faxed reports when requested	1	2	3	4	5
Ease of access to Amicas	1	2	3	4	5
Quality of Amicas images	1	2	3	4	5
Receive wet reads when requested	1	2	3	4	5
Efficiency of film delivery	1	2	3	4	5
Courtesy of film delivery courier	1	2	3	4	5

TECHNICAL SERVICES:

Level of professionalism/knowledge of technical staff	1	2	3	4	5
Technologist interaction with your patients	1	2	3	4	5
Feedback from patients about technologists	1	2	3	4	5

OVERALL SERVICES

Selection of appointment times	1	2	3	4	5
Availability of urgent appointments	1	2	3	4	5
Days/hours of service	1	2	3	4	5
Patient wait time	1	2	3	4	5
Level of knowledge/courtesy of billing office staff	1	2	3	4	5
Feedback from your patients about office staff	1	2	3	4	5

Quality of professional readings:

MRI	1	2	3	4	5
CT	1	2	3	4	5
Mammography	1	2	3	4	5
Ultrasound	1	2	3	4	5

Quality of images:

MRI	1	2	3	4	5
CT	1	2	3	4	5
Mammography	1	2	3	4	5
Ultrasound	1	2	3	4	5

Overall experience	1	2	3	4	5
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Please complete reverse side for needs assessment.

NEEDS ASSESSMENT

Please rate the importance of the following:

1 =not important, 2 = slightly important, 3 = important, 4 = very important, 5 = essential

Reputation of faculty and CPER	1	2	3	4	5
Accessibility of Radiologists	1	2	3	4	5
Office visit from Marketing Representative	1	2	3	4	5
Quality of diagnostic equipment	1	2	3	4	5
Travel distance for patient	1	2	3	4	5
Availability of parking	1	2	3	4	5
Participation with managed care plan	1	2	3	4	5
Availability of urgent and same-day appointments	1	2	3	4	5
Access to electronic (digital) images	1	2	3	4	5
Receipt of films with negative findings	1	2	3	4	5
Receipt of films with positive findings	1	2	3	4	5
Wet readings	1	2	3	4	5
I.V. sedation available	1	2	3	4	5

Who typically schedules imaging services for your office?

Patient

Physician

Office Staff

Who selected CPER? _____

Your Medical Specialty _____

If you were not aware we provide a following service, please check: On-line reports/films __ Images on CD __ Images printed on paper __ MRA __ Virtual Colonoscopy __ Coronary Scoring __ Lung Screening __ Nuclear Medicine __ Bone Density __ Stereotactic Biopsy __ Breast MRI __

Are there any other procedures you would like is to perform?

How can our services be improved? _____

I need requisition pads/insurance list. Please send to: _____

THANK YOU FOR YOUR PARTICIPATION!
 Your response is important to us.

Name (Optional): _____ Phone: _____

Please send your questionnaire in the enclosed postage-paid return envelope, or fax to 212-326-8870, Attn: Vera Brooks
 This questionnaire is also available on our website at www.cper60th.org