Frankston Pain Management **Suite 7, 20 Clarendon St, Frankston, Vic, 3199**
Website: http://www.fpmx.com.au Email: info@fpmx.com.au Tel: 03 9770 0522 Fax: 03 9770 0944

Frankston Pain Management (FPM) Feedback Form

To help us improve our service we would be grateful if you would take a few minutes to fill in this feedback form.

Please tick if you are a Patient ☐ or Carer ☐ Date: _____

Thinking About Your Condition:

1. Were you able to ask your questions that you wanted to ask? ☐ Yes ☐ No, i*f no, give a brief note:*

_____

2. Were you able to have an understanding of your condition? ☐ Yes ☐ No, *if no, give a brief note:*

_____

3. Were you able to understand the doctor's explanation of your condition? ☐ Yes ☐ No, *If no, give a brief note:*

_____

4. Were you able to understand your treatment plan? ☐ Yes ☐ No, *if no, give a brief note:*

_____

5. Were you able to get involved in decisions regarding overall care? ☐ Yes ☐ No, i*f no, give a brief note:*

_____

Thinking About the Information We Provide, please tell us how useful you found the following information:

1. Patient information leaflets about your treatment. ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ N/A
2. Webpage content (www.fpmx.com.au). ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ N/A
3. Webpage animations (www.fpmx.com.au). ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ N/A

_____

Thinking About Our Staff:

Did the staff listen to your requests and deal with them in a timely manner? ☐ Yes ☐ No, *if no, give a brief note:*

_____

Did our staff's knowledge meet your expectation? ☐ Yes ☐ No, i*f no, give a brief note:*

_____

1. Were the staff respectful and courteous? ☐ Yes ☐ No, *if no, give a brief note:*

_____

2. Were you given the opportunity to ask questions? ☐ Yes ☐ No, *if no, give a brief note:*

_____

Thinking About the Clinic:

1. Did your visit meet your expectation? ☐ Yes ☐ No, *if no, give a brief note:*

_____

2. How comfortable was the environment? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ N/A
3. Overall satisfaction with your treatment at F PM? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ N/A
4. Would you recommend this pain clinic to others? ☐ Yes ☐ No, *if no, give a brief note:*

_____

5. If there was one thing we could do to improve your visit, what would that be?

_____

6. Do you have any additional comments? ☐ Yes ☐ No, *if yes, give a brief note:*

_____

7. Would you like us to contact you regarding this feedback? ☐ Yes ☐ No, i*f yes, please provide details below:*

Name: _____ Date of Birth: _____ Phone: _____ Email: _____

More information is available on www.fpmx.com.au