



CERTIFIED

Today's Date: _____ Patient Name (optional): _____

Sex: _____ Age: _____ Office Location: Fort Collins Greeley Denver

What type of service did you receive? (Select all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Above Knee Prosthesis | <input type="checkbox"/> AFO | <input type="checkbox"/> Below Knee Prosthesis | <input type="checkbox"/> Compression Stocking |
| <input type="checkbox"/> Upper Extremity Prosthesis | <input type="checkbox"/> UCBL | <input type="checkbox"/> Fracture Brace/Boot | <input type="checkbox"/> Hip Brace |
| <input type="checkbox"/> KAFO | <input type="checkbox"/> Knee/Elbow Immobilizer | <input type="checkbox"/> Shoe Insert | <input type="checkbox"/> Shoes |
| <input type="checkbox"/> SMO | <input type="checkbox"/> Soft Back Brace (corset) | <input type="checkbox"/> Soft Wrist/Hand Brace | <input type="checkbox"/> TLSO/LSO |
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Burn Care | <input type="checkbox"/> Custom Seating | <input type="checkbox"/> Pediatric Orthosis |

1. How long after calling for an appointment were you scheduled to be seen?

- Immediately Less than one week
 More than one week More than 2 weeks

2. When calling the office how long were you placed on hold?

- 0-30 seconds 30 seconds -1min
 1-2min more than 2min

3. At the time of delivery, was the fit and function of the finished device:

- Excellent Satisfactory Unsatisfactory

4. How well were the financial aspects of your care explained to you?

- Very well Somewhat well Not well

5. How would you rate the value of the service(s) delivered to you?

- Very valuable Somewhat valuable Not valuable

Yes No 6. Were you seen within 15 minutes of your scheduled time?

Yes No 7. In your opinion, was the staff friendly and polite at all times

Yes No 8. Was the prescribed device received in the time communicated to you?

Yes No 9. Did the device need to be remade?

Yes No 10. In your opinion, did the practitioner possess the necessary skills to provide you with the required device?

Yes No 11. Did you receive specific instructions from the practitioner?

Yes No 12. Were you scheduled for a follow-up appointment at time of delivery?

Yes No 13. Were patient waiting and treatment areas well-maintained?

Yes No 14. Would you use these services again?

Yes No 15. Are the office hours convenient?

Yes No 16. Would you recommend these services to others?

Any additional comments/observations? Please provide comments below:
