Beacon Hospital

Patient Feedback Form

Background Information:

Are you: Male / Female (please circle)

Age: ____________ (in years)

Discharge Date: _______________ (dd/mm/yy)

Primary Consultant: __________________________

Ward/Department: __________________________

Was this your first visit to Beacon Hospital: YES / NO (please circle)

Were you in an Inpatient Area / Outpatient Area (please circle)

Thank you for taking the time to give us your feedback.

Beacon Hospital

Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Overall I received excellent care & service at Beacon Hospital.					
If I had to go to hospital in the future I would choose Beacon Hospital.					
I would recommend Beacon Hospital.					

Additional Comments: