PATIENT FEEDBACK FORM

THIS IS MODERN MEDICINE

Beacon Hospital

BACKGROUND INFORMATION

Are you: Male / Female / Other (please circle)

Age: ________________(in years)

Date: ________________________

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)

PLEASE TICK AS APPROPRIATE

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

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