Patient Received Telemedicine:

☐ Assessment ☐ Treatment

☐ Consult

Telemedicine Physician ID

Date Completed (mm/dd/yyyy)

		/			/				

TELEMEDICINE SATISFACTION SURVEY

Your care and comfort is important to us and we continually want to improve our services. You can help us by taking a moment and completing this survey. Please place an X in the box below your answer and feel free to add comments or suggestions.

	Excellent	Very Good	Good	Fair	Poor
1. Your overall telemedicine experience	☐	☐	☐	☐	☐
2. The ability to develop a relationship with your telemedicine physician or clinician	☐	☐	☐	☐	☐
3. Your level of privacy with the telemedicine process	☐	☐	☐	☐	☐

4. Would you participate in telemedicine in the future?

☐ Definitely Would ☐ Probably Would ☐ Probably Would Not ☐ Definitely Would Not

5. Would you recommend using telemedicine to friends or family?

☐ Definitely Would ☐ Probably Would ☐ Probably Would Not ☐ Definitely Would Not

Comments: