Thank you for completing this survey. Please rate the services you received from our facility by filling in the box that best describes your experience. Please skip any questions that do not apply. When finished, please place in the survey box at the nurses station or mail to: **Lourdes Inpatient Rehab Dept. 520 N 4th Ave. Pasco, WA 99301**

LOURDES HEALTH

ADMISSIONS	Very Poor	Poor	Fair	Good	Very Good
1. Speed of the admissions process	☐	☐	☐	☐	☐
2. Courtesy of admissions personnel	☐	☐	☐	☐	☐
ROOM					
1. Overall room appearance	☐	☐	☐	☐	☐
2. Daily room cleaning	☐	☐	☐	☐	☐
3. Room temperature	☐	☐	☐	☐	☐
4. Noise level in and around room	☐	☐	☐	☐	☐
5. Amenities (TV, call button, lights, bed, etc.)	☐	☐	☐	☐	☐
6. Courtesy of housekeeping personnel	☐	☐	☐	☐	☐
DIET & MEALS					
1. Food temperature	☐	☐	☐	☐	☐
2. Food quality	☐	☐	☐	☐	☐
3. Menu variety	☐	☐	☐	☐	☐
4. Receiving the food you selected	☐	☐	☐	☐	☐
5. Explanation about your special diet	☐	☐	☐	☐	☐
NURSING CARE					
1. Courtesy of the nurses	☐	☐	☐	☐	☐
2. Responding to the call button promptly	☐	☐	☐	☐	☐
3. Attitude of nurses when called	☐	☐	☐	☐	☐
4. Amount of attention paid to your special or personal needs	☐	☐	☐	☐	☐
5. Participation in setting your personal care goals (hygiene, bladder & bowel routine)	☐	☐	☐	☐	☐
6. Nurses' sensitivity and responsiveness to pain you may have experienced	☐	☐	☐	☐	☐
7. Instruction received about caring for yourself at home (including medication)	☐	☐	☐	☐	☐
8. Overall nursing care on these shifts:					
a. Day Shift	☐	☐	☐	☐	☐
b. Night Shift	☐	☐	☐	☐	☐
PHYSICAL THERAPY					
1. Courtesy of your physical therapist	☐	☐	☐	☐	☐
2. Participation in setting your physical therapy goals	☐	☐	☐	☐	☐
3. Explanation of your treatment & progress	☐	☐	☐	☐	☐
4. Adequacy of your physical therapy program	☐	☐	☐	☐	☐

OCCUPATIONAL THERAPY	Very Poor	Poor	Fair	Good	Very Good
1. Courtesy of your occupational therapist	☐	☐	☐	☐	☐
2. Participation in setting your occupational therapy goals	☐	☐	☐	☐	☐
3. Explanation of your treatment & progress	☐	☐	☐	☐	☐
4. Adequacy of your occupational therapy program	☐	☐	☐	☐	☐
SPEECH THERAPY					
1. Courtesy of your speech therapist	☐	☐	☐	☐	☐
2. Participation in setting your speech therapy goals	☐	☐	☐	☐	☐
3. Explanation of your speech, language or swallowing problem & treatment	☐	☐	☐	☐	☐
4. Adequacy of your speech therapy program	☐	☐	☐	☐	☐
VISITORS & FAMILY					
1. Courtesy of the information desk personnel	☐	☐	☐	☐	☐
2. Adequacy of visiting hours	☐	☐	☐	☐	☐
3. Accommodations & comfort for visitors (lounge, restrooms, etc.)	☐	☐	☐	☐	☐
4. Staff attitudes toward your visitors	☐	☐	☐	☐	☐
5. Information provided to your family about your condition & treatment	☐	☐	☐	☐	☐
YOUR REHABILITATION DOCTOR					
1. Courtesy of your doctor	☐	☐	☐	☐	☐
2. Explanation of your rehab program	☐	☐	☐	☐	☐
3. Concern for your questions & worries	☐	☐	☐	☐	☐
4. Information about your treatment & progress	☐	☐	☐	☐	☐
5. Sensitivity & responsiveness to pain you may have experienced in the hospital	☐	☐	☐	☐	☐
6. Informative when communicating with your family	☐	☐	☐	☐	☐
7. Discussion about your discharge plans & post-discharge care	☐	☐	☐	☐	☐
8. Availability to answer your questions	☐	☐	☐	☐	☐
9. Questions explained in language you could understand	☐	☐	☐	☐	☐
10. Overall rating of the doctor	☐	☐	☐	☐	☐

COMMENTS (Please use reverse side if needed)