

In-Patient Feedback Form – Sabah Medical Centre (SMC)

Mandatory Field **° Please Select One**

Your Particulars:			
# Patient's Name:			
# Date of Admission:			
# Date of Discharge:			
# You were at:	<input type="radio"/> Intensive Care Unit	<input type="radio"/> Ward 3	<input type="radio"/> Ward 5
# If you response on behalf,			
Name:			
# Address:			
# Telephone:			
# E-Mail:			

Admission:			
	Delighted	Satisfied	Disappointed
Explanation by receptionist:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Courtesy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Nursing Care:			
Personal Care:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prompt Service:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explanation:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cheerfulness:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respond to Call:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Helpfulness:			
The Nursing Staff:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Attending Consultant(s):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Rooms:			
Cleanliness:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comfort:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facilities:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Foods:			
Taste:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Served Warm:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Presentation:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Discharge:			
Process from time informed by Doctor:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collection of Medicine:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comment, if any:			

Suggestions for Improvement			

For Office Use			
Patient No.			
Registered Name:			
Place of Birth:			
Race:			
Date of Admission:			
Date of Discharge:			
Type of Treatment:			
Require for Reply:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Remarks:			