Telemedicine Evaluation Form (version 2.3)

TM Patient Evaluation Form-UofMn

Patient ID Number: _____ **Date:** _____

This section to be completed by medical staff personnel

Clinic Site (your location):

Specialty Requested: Derm Cardio Psych Ortho Endo Gastro Neuro Pulm Other

Type of Payer: Medicare Self-Pay Work-comp BCBS Medicaid Capitated Commercial

Patient's Status: #1 Inpatient Outpatient At Home Nursing Home

Patient's Status: #2 New Established Global

This section to be completed by Telemedicine patient or patient's guardian

Thank you for participating in our Telemedicine Clinic. The information you provide to us will better assist our program and its success, as well as, help us in identifying ways to improve the existing system.

1. How many hours did you &/or your family miss from work or school, including drive time, to be at the Telemedicine clinic? _____ How many hours would you &/or your family have missed if you had to go to the specialist's office_____?

2. Approximately how many miles did you travel to use the Telemedicine facility? _____

3. How satisfied are you with today's clinic? *(Questions 3-10 please circle the most appropriate answer)*

Highly Satisfied Satisfied Not Satisfied Highly Dissatisfied

4. Overall, how satisfied are you that today's medical clinic met your current healthcare needs?

Highly Satisfied Satisfied Not Satisfied Highly Dissatisfied

5. How did you feel during today's Telemedicine visit?

Very comfortable Relaxed Tense Very Uncomfortable

6. Would you use the Telemedicine system again? If no, feel free to comment on the back of this form

Yes Not Sure No

7. Would you have preferred to see the physician in person today?

Yes Not Sure No

8. If necessary, would you drive to the Twin Cities to see the physician you saw today in clinic?

Yes Not Sure No

9. How long would you be willing to wait for an appointment to see today's Telemedicine physician in person?

One Day One week One Month More than One Month

10. How satisfied are you with the nursing staff and their knowledge?

Highly Satisfied Satisfied Not Satisfied Highly Dissatisfied

Please feel free to make any additional comments on the reverse side of this form. The Fairview-University Telemedicine program is trying to expand to more areas within Minnesota to provide high quality health care and convenient access for all the communities we serve. Thank you for using our services today and we hope you had a most satisfying experience.

COMMENTS: _____

Attachment 4: » » » » » » » »

Satisfaction Questionnaire

Final Results Report

TELEHEALTH SATISFACTION SURVEY
(FOR TELEREHABILITATION AND TELEVISITATION SESSIONS)
FAX TO : 514-398-1531

❑ Speech/language therapy ❑ Occupational therapy ❑ Physical therapy ❑ Televisitation

Patient code:_____

Gender
❑ Male ❑ Female

Age
❑ 0 - 20 ❑ 21 - 40 ❑ 41 - 60 ❑ 61 - 80 ❑ 80+

How satisfied were you with:	Poor	Fair	Good	Excellent
• The voice quality of the equipment?				
• The visual quality of the equipment?				
• Your personal comfort in using the telehealth system?				
• The length of time to get an appointment in Fort Chip?				
• The ease of getting to the telehealth department (circle one: taxi, private, walked, CHR, staff)				
• The length of time with the therapist or family member you saw?				
• The explanation of your treatment by the telehealth staff?				
• The thoroughness, carefulness and skillfulness of the telehealth staff?				
• The courtesy, respect, sensitivity and friendliness of the telehealth staff?				
• How well the telehealth staff respected your privacy?				
• How well the staff answered your questions about the equipment?				
• Your overall treatment experience at using telehealth?				

Would you use Telehealth again? ❑ No ❑ Yes

Would you recommend telehealth to another person? ❑ No ❑ Yes

Comments: _____

_____

_____

❑ **Self-administered** ❑ **With help** **By:** _____

PLEASE FAX THE COMPLETED FORMS TO: 514-398-1531. IF YOU HAVE ANY QUESTIONS OR COMMENTS PLEASE CALL 514-398-3247.

Based on a form developed by the Saskatchewan Northern Telehealth Network.

	PATIENT SATISFACTION SURVEY (USE FOR PATIENT CARE SESSIONS) FAX TO : 514-398-1531					
Patient code:_____	**Gender** Male Female	**Age** 0 - 20	21 - 40	41 - 60	61 - 80	80+
How satisfied were you with:		**Poor**	**Fair**	**Good**	**Excellent**	
• Your general health?						
• The length of time to get an appointment with Telehealth?						
• The length of time waiting in the office at Telehealth?						
• The length of time with the specialist you saw?						
• The explanation of your condition by the specialist?						
• The explanation of your treatment by the specialist?						
• The thoroughness, carefulness and skillfulness of the specialist you saw?						
• The courtesy, respect, sensitivity and friendliness of the specialist you saw?						
• How well the staff here respected your privacy?						
• How well the staff here answered your questions about the equipment?						
• How well the staff here treated you with respect?						
• Your overall treatment experience at Telehealth?						
Did you have any difficulties getting here today? No Yes: ➔ _____			**Any other comments about telehealth?** _____ _____			
Would you use Telehealth again?	No Yes					
Would you recommend telehealth to another person?	No Yes					

Self-administered **With help** **Orally By:** _____

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SONDAGE SUR LA SATISFACTION DES PATIENTS
(SÉANCES DE TÉLÉSANTÉ À LA ROMAINE)
TÉLÉCOPIER AU : 514-398-1531

Code du patient :_____ **Date:** _____

Avez-vous été satisfait(e) :	**Médiocre**	**Passable**	**Bon**	**Excellent**
• De votre état de santé général?				
• Du délai d'attente pour l'utilisation de l'équipement de télésanté?				
• Du délai d'attente pour les résultats de la séance de télésanté?				
• Du respect accordé par le personnel à votre vie privée?				
• De la manière dont le personnel a répondu à vos questions au sujet de l'équipement?				
• Du respect avec lequel le personnel vous a traité(e)?				
• De votre expérience de la télésanté en général?				

Avez-vous eu de la difficulté à vous rendre ici aujourd'hui?

Non Oui : ➔ _____

Était-ce la première fois que vous utilisiez le servicede télésanté?	Non	Oui
Utiliseriez-vous de nouveau la télésanté?	Non	Oui
Choisiriez-vous la télésanté plutôt qu'une visite chez le médecin?	Non	Oui
Recommanderiez-vous la télésanté?	Non	Oui

Avez-vous d'autres commentaires à faire à propos de la télésanté? :

_____

_____

Auto-administré Avec de l'aide
Verbalement par :

_____

VEUILLEZ TÉLÉCOPIER LES FORMULAIRES REMPLIS AU : 514-398-1531.
POUR TOUTE QUESTION OU TOUT COMMENTAIRE, PRIÈRE DE TÉLÉPHONER AU 514-398-3247.

Adapté et utilisé avec la permission du Saskatchewan Northern Telehealth Network

	PATIENT SATISFACTION SURVEY (USE FOR PATIENT CARE SESSIONS) FAX TO : 514-398-1531					
Patient code:_____	**Gender** Male Female	**Age** 0 - 20	21 - 40	41 - 60	61 - 80	80+
How satisfied were you with:		**Poor**	**Fair**	**Good**	**Excellent**	
• Your general health?						
• The length of time to get an appointment with Telehealth?						
• The ease of getting to the Telehealth site?						
• The length of time waiting in the office at Telehealth?						
• The length of time with the specialist you saw?						
• The explanation of your condition by the specialist?						
• The explanation of your treatment by the specialist?						
• The thoroughness, carefulness and skillfulness of the specialist you saw?						
• The courtesy, respect, sensitivity and friendliness of the specialist you saw?						
• How well the staff here respected your privacy?						
• How well the staff here answered your questions about the equipment?						
• How well the staff here treated you with respect?						
• Your overall treatment experience at Telehealth?						

To use the telehealth service today, did you have to:

Arrange child care? No Yes: Cost to you: $_____

Pay for any costs? No Yes: About how much (not child cost) $_____

Would you use Telehealth again? No Yes

Would you recommend telehealth to another person? No Yes

Any other comments about telehealth?

_____

_____

Self-administered With help Orally By: _____

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