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Madison Surgery Center
P.O. Box 1328
Madison, WI 53701-1328

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Madison Surgery Center
Attn: Medical Records
PO Box 1328
Madison, WI 53791-7890

MADISON SURGERY CENTER
QUESTIONNAIRE

You recently received care at the Madison Surgery Center. Your health care team would like to hear your thoughts about your experience at the surgery center. Your feedback on the enclosed survey will help us improve the care and service we provide to all our patients. You can respond by completing the printed survey provided here.

Please mark the response that most closely reflects your experience.	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree	Does Not Apply
1. I was informed about what to expect on the day of my procedure.	☐	☐	☐	☐	☐	
2. I was kept informed of any/all delays.	☐	☐	☐	☐	☐	☐
3. My needs were handled promptly and efficiently by the admission staff.	☐	☐	☐	☐	☐	
4. On the day of my procedure, the sequence of events was explained to me.	☐	☐	☐	☐	☐	
5. The clinical staff was responsive to my needs and concerns.	☐	☐	☐	☐	☐	
6. My surgeon showed concern and sensitivity to my needs.	☐	☐	☐	☐	☐	
7. My anesthesiologist showed concern and sensitivity to my needs.	☐	☐	☐	☐	☐	☐
8. The needs of my family/support person were met during my stay at Madison Surgery Center.	☐	☐	☐	☐	☐	
9. The clinical team kept me informed about what was taking place during my stay at Madison Surgery Center.	☐	☐	☐	☐	☐	
10. I was satisfied with the way my pain was addressed.	☐	☐	☐	☐	☐	
11. Medication and care at home were explained to me in a way I could understand.	☐	☐	☐	☐	☐	
12. My privacy was respected during my entire stay at Madison Surgery Center.	☐	☐	☐	☐	☐	
13. I knew who to call if I had questions or concerns after my stay at Madison Surgery Center.	☐	☐	☐	☐	☐	
14. I consistently received respect and compassion while at Madison Surgery Center.	☐	☐	☐	☐	☐	
15. I would recommend Madison Surgery Center without hesitation to others.	☐	☐	☐	☐	☐	

If you have any suggestions or comments, please print them in the box below.

Please indicate the area of service for which you received care: ☐ Colonoscopy ☐Cataract ☐Pain ☐Surgical/Procedure

Date of Visit: MONTH DATE YEAR

		/			/				

Name(optional) _____

Thank you for your comments. Please fold, tape shut, and return.