

Patient feedback questionnaire

Q1. Making an appointment and waiting to see a clinician at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Getting an appointment for a time that suited you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Ease of parking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. The comfort of the waiting room	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about making an appointment and waiting to see a clinician?

Q2. Your experience with reception staff at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Were professional in dealing with you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Considered your needs when making an appointment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Let you know about any delays while you were waiting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about your experience with reception staff at your last visit?

Q3. Your experience of the interpersonal skills of the clinician at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Understood your personal circumstances	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Had enough time to talk about the things that were important for you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Made you feel comfortable	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d. Showed sensitivity to your concerns	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
e. Told you all you wanted to know about your condition	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about your experience with clinical staff at your last visit?

Q4. Your experience of the way clinicians communicated with you at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. The clinician had enough time to listen to what you had to say	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Helped you understand your medical condition	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Helped you understand what to do when you went home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d. Guided you on how to take medicines correctly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
e. Allowed you to have final choice about treatments	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about the way clinicians communicated with you at your last visit?

Q5. Your experience of the information given to you by clinicians at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Information about side effects of any treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Information about how to stay healthy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Information about how to prevent future health problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about the information given to you by clinicians at your last visit?

Q6. Your experience of privacy at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Privacy when you were examined	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Privacy in the waiting area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Being able to discuss personal issues that were sensitive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about your experiences of privacy at your last visit?

Q7. Your experience of the way your clinician worked with other healthcare professionals at your last visit

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Knew your medical history at the clinic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Gave you options for specialists or other health providers you need to see	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. Allowed you to have the final choice about which other professionals to see	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about the way your clinician worked with other healthcare professionals at your last visit?

Q8. Thinking about your experience with the general practice over the past year

Please rate each statement

Statements	Poor	Fair	Good	Very good	Excellent	N/A	Don't Know
a. Suitability of clinic opening hours	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
b. Information about where to get medical care when the clinic is closed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
c. The amount you paid for each visit to the doctor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
d. Providing your test results in an understandable way	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Do you have any comments you would like to make about your experience with the general practice over the last year?

Q9. If you could change one thing about the practice, what would you change?

Please write your ideas below:

Some things about you

Q10. How do you describe your gender?	Q11. Do you consider yourself to be of Aboriginal and/or Torres Strait Islander descent?
<input type="checkbox"/> ₁ Man or male <input type="checkbox"/> ₂ Woman or female <input type="checkbox"/> ₃ Non-binary <input type="checkbox"/> ₄ [I/they] use a different term (please specify) <input type="text"/> <input type="checkbox"/> ₅ Prefer not to answer	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Q12. Have you been to another general practice in the last year?	Q13. Which languages do you speak at home? Tick all spoken
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ English <input type="checkbox"/> ₂ Arabic <input type="checkbox"/> ₃ Cantonese <input type="checkbox"/> ₄ Mandarin <input type="checkbox"/> ₅ Vietnamese <input type="checkbox"/> ₆ Hindi <input type="checkbox"/> ₇ Greek <input type="checkbox"/> ₈ Other
Q14. What is your age?	
<input type="checkbox"/> ₁ 15 – 24 years <input type="checkbox"/> ₂ 25 – 44 years <input type="checkbox"/> ₃ 45 – 64 years <input type="checkbox"/> ₄ 65 years or over <input type="checkbox"/> ₅ Don't wish to say	
Q15. How long have you been coming to this practice?	Q16. Do you have any of these concession cards?
<input type="checkbox"/> ₁ Less than 1 year <input type="checkbox"/> ₂ 1 – 2 years <input type="checkbox"/> ₃ 3 years or more <input type="checkbox"/> ₄ Not sure	<input type="checkbox"/> ₁ Health Care Card <input type="checkbox"/> ₂ Pensioner Concession Card <input type="checkbox"/> ₃ Any Veterans' Affairs treatment entitlement card <input type="checkbox"/> ₄ Not covered by any concession card
Q17. How many times have you visited this practice over the past 12 months?	Q18. What is the highest level of education you have reached?
<input type="checkbox"/> ₁ Only this visit <input type="checkbox"/> ₂ 2 – 5 <input type="checkbox"/> ₃ 6 – 10 <input type="checkbox"/> ₄ 11 or more <input type="checkbox"/> ₅ Not sure	<input type="checkbox"/> ₁ Some high school <input type="checkbox"/> ₂ Completed high school <input type="checkbox"/> ₃ Currently studying for a degree or diploma <input type="checkbox"/> ₄ Completed a trade or technical qualification <input type="checkbox"/> ₅ Completed a degree or diploma <input type="checkbox"/> ₆ Postgraduate degree
Q19. Was this visit for yourself or someone you are caring for?	
<input type="checkbox"/> ₁ Self <input type="checkbox"/> ₂ Someone else	

Thank you for taking the time to complete this questionnaire.

Please put the survey in the secure box provided at reception when you have finished