Central X-Ray & Ultrasound

REFERRING PHYSICIAN SURVEY

Physician Name:	**Date:**

Your feedback is very important for quality assurance, and is key to our continued efforts to deliver superior diagnostic services. This survey is provided in accordance with CPSO guidelines and standard IHF procedures.

1. I refer patients to Central X-Ray and Ultrasound (CXU) because of (check all that apply)

☐ Location ☐ Appointment Availability ☐ Range of Services Offered
☐ Report Turn-Around Time ☐ Overall Quality of Services Provided
☐ Other: ____

2. CXU requisitions are easy to use and understand

☐ Strongly Agree ☐ Somewhat Agree ☐ Neither Agree nor Disagree
☐ Somewhat Disagree ☐ Strongly Disagree

3. How satisfied are you with the quality of CXU's Diagnostic Reports?

☐ Very Satisfied ☐ Satisfied ☐ Neither Satisfied or Unsatisfied
☐ Unsatisfied ☐ Very Unsatisfied

4. How satisfied are you with CXU's Diagnostic Report turnaround time?

☐ Very Satisfied ☐ Satisfied ☐ Neither Satisfied or Unsatisfied
☐ Unsatisfied ☐ Very Unsatisfied

5. How satisfied are you with our patient appointment availability?

☐ Very Satisfied ☐ Satisfied ☐ Neither Satisfied or Unsatisfied
☐ Unsatisfied ☐ Very Unsatisfied

6. How satisfied are you with our clinic's overall quality of service?

☐ Very Satisfied ☐ Satisfied ☐ Neither Satisfied or Unsatisfied
☐ Unsatisfied ☐ Very Unsatisfied

7. Would you recommend our services to other physicians?

☐ YES ☐ NO

Why?____

8. Do you have any suggestions on how we can improve our current service delivery?

☐ YES ☐ NO

Why?____

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Providing Services in X-Ray, Ultrasound and Bone Density