

**YOUR COMMENTS ARE VERY IMPORTANT TO US.**

**A**t our center, we are always trying to improve services and comforts for our patients. Our success is measured by what you think of us and how you do after your surgery. We hope you are satisfied with the care you received at Pinnacle Surgery Center and we look forward to hearing from you!



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**Pinnacle Surgery Center**  
6790 W. Thunderbird Rd.  
Peoria, AZ 85381 USA



Name \_\_\_\_\_  
 Doctor \_\_\_\_\_  
 Date of Procedure \_\_\_\_\_

- Pain Management
- General
- Regional
- IV Sedation
- Local

We are pleased to have had you as a patient at Pinnacle Surgery Center and would appreciate your completing this questionnaire two weeks following treatment as we value **your** opinion.

**PREOPERATIVE**

If you asked questions about the financial arrangements did we answer courteously in a manner you understood clearly? YES \_\_\_\_\_ NO \_\_\_\_\_

Did your instructions before the day of surgery adequately prepare you? YES \_\_\_\_\_ NO \_\_\_\_\_

**ON DAY OF PROCEDURE**

Was our center clean and comfortable? YES \_\_\_\_\_ NO \_\_\_\_\_

Was our staff courteous and responsive to your needs? YES \_\_\_\_\_ NO \_\_\_\_\_

Was your anesthesia or pain management treatment and its effects explained to your satisfaction?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

Did our nurses clearly and thoroughly explain the instructions for your care at home?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

**HOME RECOVERY**

Did you experience any **UNEXPECTED** problems after your procedure?

- |   |                            |
|---|----------------------------|
| discharge from incision or injection site _____ | excessive bleeding _____   |
| pain unrelieved by prescribed medication _____  | headache _____             |
| fever greater than 100.5 _____                  | difficulty breathing _____ |
| vomiting or nausea for several hours _____      | prolonged numbness _____   |

If you experienced any of the above, did you contact your doctor? YES \_\_\_\_\_ NO \_\_\_\_\_

Go to an Emergency Room? YES \_\_\_\_\_ NO \_\_\_\_\_

Over all, was your experience at Pinnacle Surgery Center:  
 EXCELLENT \_\_\_\_\_ GOOD \_\_\_\_\_ POOR \_\_\_\_\_

What could we have done to make your stay with us more comfortable?

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Relationship if other than patient \_\_\_\_\_

**THANK YOU!**