

Information

Pediatric Telemedicine Program Patient Feedback Form

Thank you for completing this survey. When you are done, please mail or fax it to us at 404-785-9239.

Child's Name (optional)Telephone Number May we contact you about this survey? YES NO Date of visit: What is the name and/or specialty of the physician you saw?											
						Please check the box that matches your feeling about your child's ex	kperience.	-			
						Appointment & Check-In	very poor 1	poor 2	fair 3	good 4	very good 5
Overall satisfaction with making an appointment and instructions prior to visit											
Speed and courtesy of staff when checking in upon arrival											
Comments:											
Your child's visit	very poor 1	poor 2	fair 3	good 4	very good 5						
Provider introduced themselves and was friendly, courteous and showed concern for your child											
Trust you had in your child's provider											
Comments:											
Facility	very poor 1	poor 2	fair 3	good 4	very good 5						
Felt comfortable seeing your provider via telemedicine											
Facility is accessible, comfortable and clean											
Name of facility:											
Comments:											
Overall Service	very poor 1	poor 2	fair 3	good 4	very good 5						
Likelihood to pick telemedicine over in person care											
Likelihood to pick telemedicine over no care at all											
Likelihood to recommend telemedicine to others											
Overall rating of care											
Comments:											