Physician Survey for SWDC’s Imaging Center

Facility Name: ________________________________________________________________

Physician: __________________________________ Date: ______________________________

1. Please rate the overall radiology report quality.
   □ Excellent □ Good □ Fair □ Poor

2. Please rate the overall image quality.
   □ Excellent □ Good □ Fair □ Poor

3. Please rate your satisfaction level with our report turnaround time.
   □ Very Satisfied □ Satisfied □ Somewhat Unsatisfied □ Very Unsatisfied

4. Do our radiologists provide quick consultation call backs?
   □ Yes □ No □ Sometimes

5. Please rate your level of satisfaction at how quickly patients get scheduled for an imaging procedure.
   □ Very Satisfied □ Satisfied □ Somewhat Unsatisfied □ Very Unsatisfied

6. Please rate the overall quality of our service to and treatment of patients.
   □ Excellent □ Good □ Fair □ Poor

7. Does our marketing team do a good job of communicating with you and your staff?
   □ Yes □ No □ Sometimes

8. Have you received any patient complaints regarding our service? (If yes, please explain)
   □ Yes ______________________ □ No □ Sometimes____________________

9. Have you received any positive patient feedback regarding our service or facility? (If yes, please explain)
   □ Yes ______________________ □ No □ Sometimes____________________

10. What modalities, imaging applications or services would you be interested in that we currently do not provide?
    ______________________________________________________________________
    ______________________________________________________________________
11. If a radiologist was to provide a lecture on a radiology topic, what would be of most interest to you?

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____________________________________________________________________________

12. Would you refer us to a colleague?
☐ Yes    ☐ No

13. Will you continue to send us patients?
☐ Yes    ☐ No

14. What percentage of referrals do you send to our site?
☐ 0-25%   ☐ 26-50%   ☐ 51-75%   ☐ 76-100%

15. What reasons cause you to send patients to another imaging facility?

____________________________________________________________________________

____________________________________________________________________________

16. Which days of service do you prefer (select all that apply)?
☐ Mon    ☐ Tues    ☐ Wed    ☐ Thurs    ☐ Fri    ☐ Sat    ☐ Sun    ☐ No preference

17. What time of day do you prefer to have your patients scanned (select all that apply)?
☐ Early Morning    ☐ Morning    ☐ Afternoon    ☐ Early Evening    ☐ Late Evening

General Comments and Suggestions on How We Can Improve Our Services to You and the Patient:

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Thank you very much for your time! Your feedback will enable us to improve our level of service offering to you, your staff and our patients.

Pleas Fax Completed Survey to 719-380-7510 Attention: Marketing