



Patient Enablement and Satisfaction Survey v. 2

Thank you for answering this anonymous survey which will not identify you personally in any way. The questions will provide important information about your experience with the health care at this clinic.

This survey will take about **10 minutes** to complete.

How to fill in this survey

Most of the questions can be answered by placing a tick in the box next to the answer that best applies. Please **tick only one answer** for each question unless otherwise directed.

Please return your completed survey to the reception staff or return it using the reply-paid envelope provided.

If you have any questions about this survey, you can contact:

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1. About You

a. Your age: _____

b. Your gender: Male Female Other

c. Overall, how do you rate your health? Excellent Very good Good Fair Poor

d. Do you have a long-term illness or disability? Yes No Don't Know

e. How many times have you seen a nurse at this GP practice in the past 12 months? 0 1 – 3 4 – 6 7 – 10 More than 10

f. For how long have you been attending this GP practice? _____

- g.** Do you prefer to see or speak to a particular nurse? Yes No There is usually only one nurse at this practice This is my first visit with a nurse at this practice
- ↓

If yes, do you make appointments to see a particular nurse? Yes No

2. About your visit with the nurse at this GP Practice today

h. Reason (health problem) for seeing the nurse: _____

- i.** Was this visit related to your long-term illness or disability? Yes No Not applicable

- j.** Have you been seen by this nurse before? Never 1-5 times 6-10 times More than 10 times
 Don't know

- k.** How well do you feel that you know this nurse? Not at all A little Well Very well

- l.** How long was your consultation with the nurse? 0 - 5 minutes 6 - 10 minutes 11 - 15 minutes More than 15 minutes

- m.** Was your consultation with the nurse interrupted? No Once Twice Three or more times

- n.** Did you pay to see the nurse today? Yes No



If yes, how much did you pay? _____

3. Satisfaction with your visit with the nurse at this GP practice today

Please respond to the following statements by ticking one box on each line:

| | Strongly disagree | Disagree | Uncertain | Agree | Strongly agree | Not applicable |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. The nurse was understanding of my personal health concerns | <input type="checkbox"/> |
| b. The nurse gave me encouragement in regard to my health problem | <input type="checkbox"/> |
| c. I felt comfortable to ask the nurse questions | <input type="checkbox"/> |
| d. My questions were answered in an individual way | <input type="checkbox"/> |
| e. I was included in decision-making | <input type="checkbox"/> |
| f. I was included in the planning of my care | <input type="checkbox"/> |
| g. The treatment I received was of a high quality | <input type="checkbox"/> |
| h. Decisions regarding my health care were of high quality | <input type="checkbox"/> |
| i. The nurse was available when I needed him/ her | <input type="checkbox"/> |
| j. The nurse appointment time was when I needed it | <input type="checkbox"/> |
| k. The nurse spent enough time with me | <input type="checkbox"/> |
| l. I was confident with the nurse's skills | <input type="checkbox"/> |
| m. The nurse was very professional | <input type="checkbox"/> |
| n. Overall, I was satisfied with my health care | <input type="checkbox"/> |
| o. The care I received from the nurse was of high quality | <input type="checkbox"/> |

3. As a result of seeing the nurse today, do you feel you are:

Please respond to the following statements by ticking **one** box on **each** line:

| | Same or less | Better | Much better | Not applicable |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| p. Able to understand your illness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Able to cope with your illness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Able to keep yourself healthy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Same or less | More | Much more | Not applicable |
| s. Confident about your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Able to help yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Do you have any further comments?

Thank you!