Patient Experience Survey on Ambulatory Epistaxis Pathway

This patient experience survey is anonymous and voluntary for patients who were managed on the ambulatory pathway.

* Required

* This form will record your name, please fill your name.

1. How safe did you feel during daytime in the treatment period? *

- ◯ Very safe
- ◯ Somewhat safe
- ◯ Neither safe nor unsafe
- ◯ Somewhat unsafe
- ◯ Very unsafe

2. How safe did you feel during night time in the treatment period? *

- ◯ Very safe
- ◯ Somewhat safe
- ◯ Neither safe nor unsafe
- ◯ Somewhat unsafe
- ◯ Very unsafe

3. How much pain did you experience at home? (0 = no pain, 10 = extreme/worst pain possible) *

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

4. How well organised was your treatment? *

- ◯ Extremely well organised
- ◯ Somewhat well organised
- ◯ Neutral
- ◯ Somewhat disorganised
- ◯ Extremely disorganised

5. How well do we listen and explain? *

- ◯ Extremely well
- ◯ Somewhat well
- ◯ Neutral
- ◯ Somewhat not well
- ◯ Extremely not well

6. Overall, how satisfied were you with your treatment? *

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

7. How likely are you to recommend this ambulatory pathway to friends and family if they had the same problem as you? *

- ◯ Very likely
- ◯ Somewhat likely
- ◯ Neither likely nor unlikely
- ◯ Somewhat unlikely
- ◯ Very unlikely

8. Do you have any other comments or feedback for us? *