



**HOPE**  
CONSORTIUM

SUPPORTING  
TREATMENT &  
RECOVERY IN THE  
NORTHWOODS

**Administrative Use Only**

- Ascension     FHC  
 HOPE CC     Options/Koinonia  
 FCP AODA     Price Co  
 Iron Co     Sokaogon Comm  
 LDF FRC     HSC

## ***PATIENT SATISFACTION SURVEY***

Please rate your level of agreement with the following statements about the treatment and support services you received at this facility. Select "Does Not Apply" if the statement does not apply to you or if you received the service somewhere else.

Statement	Agree	Neutral / Uncertain	Disagree	Does Not Apply
<b>1. I am satisfied with...</b>				
The overall treatment program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication-assisted treatment (MAT), such as Suboxone or Vivitrol. <i>Please indicate where MAT received or select "Does Not Apply"</i> <input type="checkbox"/> Family Health Center <input type="checkbox"/> Ascension <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care coordination services. <i>Please indicate who provided services or select "Does Not Apply"</i> <i>May select more than one</i> <input type="checkbox"/> HOPE <input type="checkbox"/> Family Health Center <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Appointments were offered at times that worked well for me.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Information about my treatment was clearly explained.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. I understood expectations of the treatment program.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. I was actively involved in developing my treatment and/or service plan.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Treatment/services I received helped me to understand and manage my substance use disorder.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. I felt safe while receiving treatment/services.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. Providers and staff were professional and welcoming.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Providers and staff listened to me.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10. I felt motivated and encouraged by providers and staff.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. Please provide the name of anyone who was particularly helpful to you:</b>				
<b>12. Services were available to help me deal with financial concerns.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>13. The facility felt welcoming and safe.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. What part of treatment or which services made the biggest difference for you?

15. If you could change one thing to improve your experience, what would it be?

**Thank you for taking the time to complete this survey.**

**If you would like to share additional comments, you may:**

1. Contact the Marshfield Clinic Health System – Center for Community Health Advancement by phone at 715-221-8400 or email at [communityhealth@marshfieldclinic.org](mailto:communityhealth@marshfieldclinic.org)

**OR**

2. Provide your name and phone number and/or email address below and someone from the HOPE Consortium will contact you. Sharing this information is **optional**.

Name: \_\_\_\_\_

Phone number and/or email address: \_\_\_\_\_