



## Post Admission Survey

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_

	YES	NO
1. After you were notified that you were to receive a call from the Agency in a timely manner to set up your initial visit?	<input type="checkbox"/>	<input type="checkbox"/>
2. Did your admitting professional give you the telephone number and contact person at the agency in case you had any questions or concerns, including after-hours information?	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you participate in your Plan of Care?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you receive information on your Bill of Rights including the State Hotline number to call if you have any complaints?	<input type="checkbox"/>	<input type="checkbox"/>
5. Did the agency admitting nurse present a professional appearance?	<input type="checkbox"/>	<input type="checkbox"/>
6. Did the nurse wear a name tag and introduce himself/herself as a representative of the agency and explain his/her role?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did the nurse leave a folder with information about your care in home?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you understand the services that your doctor ordered?	<input type="checkbox"/>	<input type="checkbox"/>
9. Did the staff tell you the date of your next visit and the frequency of visits?	<input type="checkbox"/>	<input type="checkbox"/>
10. Did the nurse take your temperature, pulse, respirations and blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Did the nurse wash her hands before and after caring for you?	<input type="checkbox"/>	<input type="checkbox"/>
12. Did the nurse teach you about:	<input type="checkbox"/>	<input type="checkbox"/>
Your medications?	<input type="checkbox"/>	<input type="checkbox"/>
Signs and Symptoms to report to the doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Your Diet?	<input type="checkbox"/>	<input type="checkbox"/>
Wound Care (if applicable)?	<input type="checkbox"/>	<input type="checkbox"/>
Plans for discharge (if applicable)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you feel the nurse answered your questions appropriately?	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**

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**PLEASE RETURN THIS SURVEY TO THE NURSE OR MAIL IT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE  
THANK YOU FOR HELPING US IMPROVE OUR SERVICES**