



Patient Satisfaction Survey
Facility Sleep Study

We would like to thank you for taking the time to provide us with feedback on your recent visit to one of our network providers. With your feedback we will continue to concentrate on improving the level of quality our patients receive when utilizing the services provided by the Sleep Management Solutions network.

On a scale of 1 to 5 – with 1 being Excellent and 5 being Poor, please rate the following:

- 1) Your appointment for your sleep study was scheduled within a sufficient period of time (3 weeks or less).
2) Your appointment for set-up on your Positive Airway Pressure Device was scheduled within a sufficient period of time (1 week or less).
3) Did the sleep lab office staff greet you properly and provide you the level of service you expected?
4) Were you taken in at or before your appointment time?
5) Did the sleep technologist treat you professionally and courteously?
6) Would you recommend this provider to your friends and relatives?
7) Rate your overall experience.
8) What would you do to improve the service of the provider?

Thank you

Date Service of Sleep Study: Facility Name:
Name (optional): Appointment Time: