



**CAIRNS  
OCCUPATIONAL  
THERAPY**

### Patient Feedback Questionnaire

We are interested in your feedback and greatly value your comments. Read these statements and indicate whether you agree or not with them, by ticking the appropriate box. This questionnaire can be anonymous.

Please return by  
**Placing in box at reception**  
 or Fax: 4051 5507  
 Email: [admin@cairnsot.com](mailto:admin@cairnsot.com)  
 Post: P.O. Box 27 Cairns Qld 4870

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree	Not Applicable
<b>Quality of Care</b>						
1. My therapist took time to fully answer my questions.						
2. My therapist appeared to understand how this injury has affected my current life situation.						
3. My therapist was respectful and patient with me.						
4. When I called Cairns OT I felt the office staff were friendly, professional & helpful.						
<b>Technical Quality</b>						
5. My therapist explained my injury and treatment in words I could understand.						
6. My therapist was experienced in the treatment of patients with injuries such as mine.						
7. The appearance of the therapy staff was professional.						
8. My medical information was kept private and confidential.						
<b>Accessibility of Care</b>						
9. I was able to make my appointment for the day & time that was convenient for me.						
10. The waiting time on the day of my appointment was acceptable. I did not have to wait long in the waiting room.						
11. My therapy was worth the time & money I / my insurer invested.						
<b>Physical Environment</b>						
12. The practice was clean and orderly.						
13. My privacy was respected during my treatment session.						
<b>Outcome of Care</b>						
14. My therapy was coordinated with my doctor, case manager and others involved.						
15. Therapy has been useful to me in gaining as much function as I can.						
16. Would you recommend a friend to our service?						

Please add suggestions for improving our Occupational Therapy service.

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Other comments

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The therapist/s I consulted with were Kerry / Nicola / Rebecca / Thomas / Bec \_\_\_\_\_

Approximately how long have you been receiving services by Cairns Occupational Therapy? (*weeks*) \_\_\_\_\_

The services I received from Cairns Occupational Therapy were? \_\_\_\_\_

Optional: Your name: .....

***Thank you for your time and interest in completing this questionnaire. We hope that the information will assist us to continually improve the service that we provide. Please feel free to call us if you would like to discuss further.***