CAIRNS
OCCUPATIONAL
THERAPY

Referrer Satisfaction 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
Fax: 4051 5507
Email: admin@cairnsot.com
Post: P.O. Box 27 Cairns Qld 4870

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree	Not Applicable
Quality of Care						
1. The referred patient was seen promptly						
2. The information that was sent back to me assisted in patient care						
3. The therapist was knowledgeable in the area required						
4. I believe the patient had a clear understanding of their home program						
5. Therapy enabled my patient to gain as much function as they could in everyday activities.						
6. I would refer future patients to Cairns Occupational Therapy						

Do you have any additional comments that may assist us in providing a better service in the future?

_____

_____

Which Service did you request?

Hand and Upper Limb Therapy / Scar/wound Management / Soft tissue injury management / Home Assessment / Equipment prescription / CRPS Management / Return to Work Services / Post Mastectomy Treatment / Lymphoedema Management

Other _____

The treating therapist/s were _____

Do you have any suggestions for our practice to ensure people can access our services? _____

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.