QUALITY OF SERVICES SURVEY
Hospital Nurse / Attending / Patient

Name: (Optional)	
Hospital/Sending Facility:	
Date:	Time:
Attendant Names:	

For each item identified below, please circle the number
that best indicates your impression of RNR's quality of service.
Utilize the scale (1-5) to select the appropriate number.

Description / Identification of Survey Item	**Scale Poor----------Excellent**				
1. Did the RNR Team arrive on time for the transfer?	NO			YES	
2. Was the RNR Team courteous, friendly and helpful to the patient and hospital staff?	1	2	3	4	5
3. Was the team compassionate to the patient and their needs while transferring from the bed to the stretcher?	1	2	3	4	5
4. Were the RNR attendants offering assistance to you while enroute and/or at the receiving facility?	1	2	3	4	5
5. When waiting at a receiving facility, did at least one attendant remain with you to assist with patient care?	1	2	3	4	5
6. Rate the quality of driving exhibited by RNR attendants.	1	2	3	4	5
7. Rate the appearance of the vehicles' interior.	1	2	3	4	5
8. Rate the appearance of the vehicles' exterior. (Weather permitting)	1	2	3	4	5
9. Rate the appearance of the attendants / drivers.	1	2	3	4	5
10. How did you find the booking process? (If applicable)	1	2	3	4	5
11. Was our dispatch staff friendly and helpful? (If applicable)	1	2	3	4	5
12. Rate the professionalism of the service offered to you by the attendants.	1	2	3	4	5
13. Rate your impression of the patients experience with RNR.	1	2	3	4	5
14. Would you recommend RNR to others?	1	2	3	4	5
15. Rate your overall experience with RNR.	1	2	3	4	5

RNR is pleased to accept any suggestions to better improve our service. As well as, any positive comments RNR management could pass on to attendant(s), or the team as a whole.

Thank you for allowing the RNR team to serve your transfer needs. Your feedback is appreciated and valued.

"Demonstrating RNR's commitment to patient care"