Imaging Services
Referrer feedback and complaints form

As we strive to consistently improve our services, we seek your feedback. Please help us by taking a few minutes to answer the following questions:

Date: _____

How would you rate:	Excellent	Good	Satisfactory	Poor
• the ability to get a timely appointment for your patient?	☐	☐	☐	☐
• the ease of making a referral request for your patient?	☐	☐	☐	☐
• the overall communication from our staff?	☐	☐	☐	☐
• the availability of a report in an appropriate time?	☐	☐	☐	☐
• the overall quality of the report?	☐	☐	☐	☐
• the availability of staff to discuss the report if needed?	☐	☐	☐	☐
• the care, professionalism and skill of our staff?	☐	☐	☐	☐
• your overall experience?	☐	☐	☐	☐

Please turn over

What did you like about our service?

What did you dislike about our service? In the future, what could we do differently?

Additional comments or suggestions:

If this is a complaint, what outcome are you seeking?

The following information is optional, but is required if you wish to be contacted:

Name:

Email:

Phone: