

# Friends and Family Test



## Example

### You can help this general practice improve its service

- This practice would welcome your honest feedback
- All the information provided by patients is put together in a report for the practice. Your answers will not be identifiable. Any comments you make will be included but all attempts will be made to remove information that could identify you.
- Once completed, please return this survey to reception in the envelope provided

Please mark the box like this  with a blue or black ball-point pen. If you change your mind just cross out your old response and make your new choice.

## We would like you to think about your recent experience of our service

|          |   |
|----------|---|
| <b>1</b> | <b>How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment?</b>                                |
|          | Extremely likely      Likely      Neither likely nor unlikely      Unlikely      Extremely unlikely      Don't know                                   |
|          | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

|          |  |
|----------|--|
| <b>2</b> | <b>Please tell us why you answered as you did in questions 1</b> |
|----------|--|

Please select this box if you DO NOT wish your comments to be made public

| Please rate the following |  | Poor                     | Fair                     | Good                     | Very good                | Excellent                | No experience            |
|---------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 4                         | Speed at which the telephone was answered initially                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5                         | Length of time you had to wait for an appointment from initial request       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6                         | The opportunity of seeing the doctor of your choice                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7                         | Opportunity of speaking to a Doctor or Nurse on the telephone when necessary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8                         | The helpfulness of the Reception staff                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please turn over ↶



**9 Are you:**

Male  Female

**10 What age are you?**

0 - 15  16 - 24  25 - 34  35 - 44  45 - 54  55 - 64

65 - 74  75 - 84  85+

**11 What is your ethnic group?**

White  Mixed/Multiple ethnic groups  Asian/Asian British

Black/African/Caribbean/Black British  Other ethnic group

**12 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? (include any issues/problems related to old age)?**

Yes, limited a lot      Yes, limited a little      No      Prefer not say

**Thank you for your time and assistance**

