



Northern Open MRI

1955 DeKalb Avenue
Sycamore, IL 60178
(815) 754-4100

Patient Survey

Date: _____

Name of Patient(optional): _____

1. *How were you treated when you called to schedule your test?*

Excellent_____ Good_____ Fair_____ Poor_____ Very Poor_____

2. *What are your general impressions of the office itself?*

Excellent_____ Good_____ Fair_____ Poor_____ Very Poor_____

3. *How would you rate the quality of care you received?*

Office Staff:

Excellent_____ Good_____ Fair_____ Poor_____ Very Poor_____

Technical Staff:

Excellent_____ Good_____ Fair_____ Poor_____ Very Poor_____

4. *Were the tests performed adequately explained and all of your questions answered?*

Yes_____ No_____

5. *Was the facility easy to locate?*

Yes_____ No_____

6. *How did you hear about our facility?*

Doctor's office_____ Friend_____ Website_____ Other_____

7. *If a friend of yours were in need imaging services, would you recommend us?*

Yes_____ No_____ Why?_____

8. *Do you have any comments or suggestions which might help us to improve our service to you? All comments, positive or negative, are appreciated.*

