

PERCEPTIONS OF CARE (OUTPATIENT VERSION)

INSTRUCTIONS TO STAFF: Please fill in your organization's User ID and the respondent's Identification Number and Intake Date, one digit in each box. Fill in the Level of Care, Time Point, and Program Type using the codes below.

User ID Unit ID

Client Identification Number

Intake Date / /
 Month Day Year

Level of Care 1 = Outpatient 2 = Partial/Day Hospital

Time Point..... 1 = Mid-Treatment 2 = End of Treatment 3 = Post-Discharge Follow-up.....

Program Type. 1 = General Adult 4 = Affective/Mood Disorders 7=Substance Abuse/Chemical Dependency
 2 = Child/Adolescent 5 = Psychotic Disorders 8 = Dual Diagnosis
 3 = Geriatric 6 = Anxiety Disorders/Trauma 9 = Other.....

INSTRUCTIONS TO RESPONDENT: We would like to know your views about the services you have been receiving as an outpatient at this facility. We will use this information to improve our quality of care. Please check the box that corresponds to your answer to each of the questions below. Please answer every question.

1. When you called to make an appointment, did you get an appointment as soon as you needed it?..... Yes No
2. Were you referred to a clinician who met your needs?..... Yes completely Partially Not at all
3. When you call or check in for appointments, are you treated with courtesy and respect?..... Never Sometimes Usually Always
4. How long do you usually wait to be seen beyond your appointment time?..... Less than 10 minutes 10-20 minutes 20-30 minutes More than 30 minutes
5. When you call your clinician, how long does it usually take for your calls to be returned?..... I have not called my clinician Less than 4 hours 4-24 hours More than 24 hours
6. Does the clinician you see explain things in a way you can understand? Never Sometimes Usually Always
7. Does the clinician you see listen carefully to you? Never Sometimes Usually Always
8. Does the clinician you see treat you with respect and dignity? Never Sometimes Usually Always

PLEASE TURN PAGE TO CONTINUE

9. Does the clinician you see give you reassurance and support? Never Sometimes Usually Always
10. Does your clinician help you learn how to deal with your problems yourself? Never Sometimes Usually Always
11. Are you involved as much as you want to be in decisions about your treatment? Never Sometimes Usually Always
12. How much does your clinician involve your family in your treatment? More than I want Less than I want About the right amount No involvement, which is what I want
13. Have you been informed about the benefits and risks of the medication you are taking? Yes No I am not taking medication
14. Have you been told what to do in case of side effects or emergency? Yes No
15. How much have you been helped by the care you received at the outpatient service? Not at all Somewhat Quite a bit A great deal
16. Is the space where you see your clinician clean and comfortable? Never Sometimes Usually Always
17. Using any number from 1 to 10, what is your overall rating of the care you received at the outpatient service? 1 2 3 4 5 6 7 8 9 10
Worst possible care Best possible care
18. Would you recommend the outpatient services at this facility to someone who needed mental health or substance abuse treatment?..... Yes Unsure No
19. Please fill in today's date.....
MONTH DAY YEAR

What services are you receiving at the outpatient department of this facility?

- | | Yes | No |
|---------------------------|--------------------------|--------------------------|
| 20. Medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Individual Therapy... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Group Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Other Treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |

24. Please identify staff whom you feel deserve special recognition.

25. Is there anything else you would like to tell us about your care?

YOUR OPINIONS ARE IMPORTANT TO US. THANK YOU VERY MUCH.