

Santa Fe Recovery Center

Outpatient Treatment Evaluation

Please take a few minutes to complete this form to assist us in our continuing efforts to improve the quality of care and services. Remember there are no right or wrong answers. Please try to answer the questions as honestly as you can. All of your responses will be kept strictly confidential.

QA. We would like to begin by asking you some **general** questions about your experience at the Santa Fe Recovery Center. For each statement below, please tell us if you strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree. **Please circle the answer that most represents how you feel.**

1 = Strongly Agree **2** = Somewhat Agree **3** = Neither Agree nor Disagree **4** = Somewhat Disagree **5** = Strongly Disagree **9** Prefer not to answer

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| 1. My admission was handled in a courteous and efficient manner. | 1 2 3 4 5 9 |
| 2. The Santa Fe Recovery Center was usually comfortable and clean. | 1 2 3 4 5 9 |
| 3. The staff was courteous, attentive, and interested in me as a person. | 1 2 3 4 5 9 |
| 4. My visitors/family were well received by staff. | 1 2 3 4 5 9 |
| 5. I was treated properly in matters pertaining to charges or arrangements for the payment/re-payment of services. | 1 2 3 4 5 9 |
| 6. I received adequate counseling, education on my addictions, and group therapy. | 1 2 3 4 5 9 |
| 7. I benefited from my treatment at the Santa Fe Recovery Center. | 1 2 3 4 5 9 |

QB. Now, we would like to ask you some questions concerning the **services** you received at the Santa Fe Recovery Center. For each statement below, please rate if the services were excellent, good, satisfactory, fair, or poor. **Please circle the answer that most represents how you feel.**

1 = Excellent **2** = Good **3** = Satisfactory **4** = Fair **5** = Poor **9** Prefer not to answer

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| 1. How would you rate the ability to access services? | 1 2 3 4 5 9 |
| 2. How do you evaluate the services provided by the counseling staff? | 1 2 3 4 5 9 |
| 3. How do you evaluate the services provided by the nursing staff? | 1 2 3 4 5 9 |
| 4. How do you evaluate the services provided by the med tech staff? | 1 2 3 4 5 9 |
| 5. How do you evaluate the service of all other staff? | 1 2 3 4 5 9 |

QC. Overall, what degree of progress did you make in reaching your goals of treatment? Please circle one answer.

1. Excellent 2. Good 3. Satisfactory 4. Fair 5. Poor 9. Prefer not to answer

DEMOGRAPHICS: Please describe yourself by checking the appropriate spaces. Please remember your answers will be kept confidential.

Age (yr.): <input type="checkbox"/> 20 – 29 <input type="checkbox"/> 30 – 39 <input type="checkbox"/> 40 – 49 <input type="checkbox"/> 50 – 59 <input type="checkbox"/> 60 + <input type="checkbox"/> Prefer not to answer	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer	Ethnic Background: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Anglo <input type="checkbox"/> Asian <input type="checkbox"/> Other (Please Specify) _____ <input type="checkbox"/> Prefer not to answer	Annual Income: <input type="checkbox"/> Less than \$10,000 <input type="checkbox"/> \$10,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$49,999 <input type="checkbox"/> \$50,000 - \$75,000 <input type="checkbox"/> \$75,000 - \$100,000 <input type="checkbox"/> \$100,000 or more <input type="checkbox"/> Prefer not to answer
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Additional Comments/Recommendations:

Your name and address are appreciated but not required. Please return this form to your primary counselor or med tech in a sealed envelope addressed to Dr. Yolanda Briscoe – Director.

Name: _____

Address: _____

Phone Number: _____

Thank you for your time.