Patient Survey

Within 72 hours of product delivery, please fax to 866-316-4259 or mail to 821 S Washington Street, Crawfordsville, IN 47933.

Crossroads Orthotics strives to enhance the quality of life and maximize the independence of the individuals we serve. Please help us provide our patients with the highest quality products and services possible by completing this form. Your local Rehab Product Specialist will also follow up on his/her next visit. If you need immediate assistance, please call 765-359-0041.

Patient: ____ Date of Service: ____________________

Product/Equipment: ____________________________________ ☐ New ☐ Existing

Access, Delivery, Fit and Service	YES	NO	N/A
1. Equipment/Supplies were delivered in a timely manner.	☐	☐	☐
2. Equipment/Supplies were ready for patient use upon delivery.	☐	☐	☐
3. Received and understood instructions on proper application and use of equipment/supplies.	☐	☐	☐
4. Feel confident to operate/use equipment/supplies and fit is satisfactory.	☐	☐	☐
5. Received info on Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	☐	☐	☐
6. Response to my questions, problems, and concerns was addressed in a timely manner.	☐	☐	☐
7. Satisfied with the equipment or supplies.	☐	☐	☐
8. Satisfied with the service/courteous/considerate staff.	☐	☐	☐
9. Would recommend to others.	☐	☐	☐

To monitor the patient's progress as it relates to the product provided, please comment on the following:

Fit of product: ____

Comfort level of patient with product: ____

Patient's condition as it relates to mobility, pain, stiffness and swelling: ___________________________________

____

Coordination of services: ____

Availity of services and examples of when patient should call for assistance: ____________________________

____

Follow-up plan: ____

Other comments: ____

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Signature: ____ Date of Survey: ____________________