“Quality is meeting our customers’ needs at all times and striving to exceed them whenever possible.”

Hertford County Emergency Services recently treated and transported you to the hospital. We would like to take this opportunity to ask for your feedback on our performance. The information you provide will assist us in continuously improving our quality of Emergency Medical Services (EMS). Our goal is to provide OUTSTANDING customer service. Please complete this survey and mail back in the enclosed envelope.

James Broglin, EMS Director

The Service You Received   Date ________________

Please select the category that best describes the reason you were transported by ambulance to the hospital. Please select only one choice.

911 Emergency Call / Transport

- Cardiac Problems (i.e. chest pain)
- Breathing problems
- Orthopedic Injury (i.e. injury)
- Allergic Reaction
- High Blood Pressure
- Stroke
- Seizure
- Diabetic Emergency
- Motor Vehicle Accident
- Other

Non-Emergency Call/Transport

- Nursing home to home
- Hospital to hospital
- Hospital to home
Transport to treatment facility

Other

How many minutes did you wait prior to calling once you began experiencing your problem?

Less than 5 minutes
More than 5 minutes
More than 10 minutes

Was service prior to:

Prior to 7 a.m.
After 7 a.m.

Our goal is to provide outstanding customer service. Please rate the service you received. Check the box that best describes your experience. If a question does not apply to you, skip to the next question.

Call to 911

The 911 call was handled in a prompt, courteous and competent manner.

Outstanding
Excellent
Average
Fair
Poor

The Ambulance Crew arrived in a timely manner.

Outstanding
Excellent
Average
Fair
Poor

The Ambulance Crew acted in a concerned and caring manner.

Outstanding
Excellent
The Ambulance Crew clearly explained the procedures they preformed.

The Ambulance Crew and equipment presented in a professional manner.

Pain and/or shortness of Breath.

Our goal is to reduce or eliminate your pain/discomfort or shortness of breath. In an effort to assess how well we did, please select one of the following:

- My pain and/or shortness of breath was reduced.
- My pain and/or shortness of breath remained the same.
- My pain and/or shortness of breath increased.

Treatment of Injuries

The methods used by the crew to splint or stabilize your injury:

- Outstanding
- Excellent
- Average
- Fair
- Poor
The methods used by the crew to move you were:

- Outstanding
- Excellent
- Average
- Fair
- Poor

The ride to the hospital did not aggravate the injury/illness:

- Outstanding
- Excellent
- Average
- Fair
- Poor

**Overall Quality**

How would you rate the overall quality of care provided to you:

- Outstanding
- Excellent
- Average
- Fair
- Poor

The overall actions of the crew caused my situation to:

- Improve
- Remain the same
- Worsen

Overall how satisfied are you with the quality of the care you received from our service.

- Outstanding
€ Excellent
€ Average
€ Fair
€ Poor

Please provide comments, that will help us improve our service.

Thank you for your participation in this survey.