

**Patient’s survey form in Karmania hospital**

Ward: ……………….., date: / /

Dear patient,

while wishing you good health, please complete this form in order to services quality improvement.

Replier: patient patients' companion degree: ………….. age: ……………. length of stay: ………………

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Num | Satisfaction of Items | Highly satisfied | Satisfied | Fairly satisfied | dissatisfied | Highly dissatisfied |
| 1 | Nurse’s self-introduction in different shifts  |  |  |  |  |  |
| 2 | Nurse’s behavior  |  |  |  |  |  |
| 3 | Timely presence of nurses  |  |  |  |  |  |
| 4 | Nurses clinical training  |  |  |  |  |  |
| 5 | Nursing assistant services in personal affairs  |  |  |  |  |  |
| 6 | Doctor’s daily visit |  |  |  |  |  |
| 7 | Doctor’s introduction, behavior and responsiveness |  |  |  |  |  |
| 8 | Providing paraclinical services |  |  |  |  |  |
| 9 | Respecting privacy in performing services  |  |  |  |  |  |
| 10 | Doctor’s clinical training  |  |  |  |  |  |
| 11 | Toilets hygiene |  |  |  |  |  |
| 12 | Amenities (refrigerator, TV, bed, ...) |  |  |  |  |  |
| 13 | Room hygiene |  |  |  |  |  |
| 14 | Room condition (noise, heat, cold, light, ...) |  |  |  |  |  |
| 15 | Cleaner’s behavior  |  |  |  |  |  |
| 16 | Foods quality and quantity  |  |  |  |  |  |
| 17 | snacks quality and variety  |  |  |  |  |  |
| 18 | Food serving time  |  |  |  |  |  |
| 19 | food serving dishes  |  |  |  |  |  |
| 20 | Food serving distributer  |  |  |  |  |  |

* Share more explanations about each of the above items and other items that may consider with us.

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* Share your suggestions and criticism with us.

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* Will you choose Karmania again?

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**Complaint, criticisms and suggestions form in Karmania Hospital**

“The experience of clients is one of the important pillars of quality improvement”

Name and surname: ……………………….. telephone number: …………………………….

Complaint type: in person / by phone / box / supervisor s' report /survey form

Complained or criticized unit or person: ………………………

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Suggestions for avoiding the issue repetition:

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Dear complainant or critic, we would like to sincerely thank you for sharing the issues. You can separate this section and contacting us to become informed of our following up process.

 Tracking code of your complaint or criticism: …………….

Contact number: 09960949001

Quality improvement office during office hours (internal number: 177 and 211 ) and supervisor s' office during non-office hours (internal number: 409 )



**Companion’s survey form in Karmania hospital**

Dear companion, with greeting and best wishes for your patient

 Please help us to provide better services by answering the following questions.

gender: male female age: ……………., patients' ward: …………………………… length of stay: ………………….

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Num | Satisfaction of Items | Highly satisfied | Satisfied | Fairly satisfied | dissatisfied | Highly dissatisfied |
| 1 | Security’s behavior |  |  |  |  |  |
| 2 | Receptionist’s behavior |  |  |  |  |  |
| 3 | Waiting time to forming the patient’s file |  |  |  |  |  |
| 4 | Amenities (prayer room, buffet , water,…) |  |  |  |  |  |
| 5 | discharging personnel s' behavior |  |  |  |  |  |
| 6 | The duration of the discharge process |  |  |  |  |  |
| 7 | Guidance signs |  |  |  |  |  |

* Have you been helped in doing the patients' procedures (receiving the medication, transferring the sample to the laboratory and etc.) ? Yes No
* Will you choose Karmania again?

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* Please share your comments, suggestions and criticisms with us:

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**Pharmaceutical combination form**

|  |  |  |  |
| --- | --- | --- | --- |
| Name and surname: | Hospitalization reason: | Age: | Sex: Male female  |
| Date of admission:Time of admission: | Ward:Bed number: | File number: | Height:Weight: |

|  |
| --- |
| Special condition: pregnancy breastfeeding alcohol consumption drug abuse others: ……………… |
| Food and drug allergy history: |
| Pharmacist: | physician:  |
| Medication reconciliation time: admission discharge  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Num | Patient’s medications\* | Medication form | Medication potency | Way of consumption  | Amount and consumption intervals | Physician’s order | Description |
| Date | Continue | Hold  | Dose change | No order |
| 1 |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |
| **\***The medication taken by the patient before admission, discharge or transfer based on patient's medical history (prescription, nonprescription, herbal, traditional and supplementary such as inhalation, topical and etc.).The source of the medical history: patient companion pervious prescription medical record etc. |
| Findings: |
| Date and time of form completion:Pharmacist’s stamp and signature:  | Date and time of form sighting:Curer physician’s stamp and signature: |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Degree: | Date of birth:  | Father’s name: | Name and surname: | File number: |
| Hospitalization reason:  | Discharge date: | Doctor | Identification ofhigh risk patientIdentification of vulnerable patient | Ward: | admission date: |
| Description of nurse and doctor | Time ofconsumption | Correctconsumption way | Consumption dose | Medications  | Num | The amount, duration and correct way of medication consumption |
|  |  |  |  |
|  |  |  |  |  |  |  |  | 1 |
|  |  |  |  |  |  |  |  | 2 |
|  |  |  |  |  |  |  |  | 3 |
|  |  |  |  |  |  |  |  | 4 |
|  |  |  |  |  |  |  |  | 5 |
|  |  |  |  |  |  |  |  | 6 |
| Notice: Continue the doctor’s medication order completely and don’t stop them even if the symptoms disappear, until your doctor hold them.Also, take your medications as prescribed by your doctor. In case of allergy with symptoms, stop them and inform your doctor. |
| In case of emergency, you can call us via 09960949001 |
| Doctor’s statement  | Nurse’s statement  | Educational titles | Num | Home care |
|  |  | Possible side effects, recommendations and warning signs(in case of occurrence, it is necessary to refer as soon as possible) | 1 |
|  |  |
|  |  |
|  |  |
|  |  | Type of nutrition (allowed and avoided) | 2 |
|  |  |
|  |  |
|  |  | Necessary care of site and the injured organ, rest and daily activity | 3 |
|  |  |
|  |  |
|  |  |
|  | laboratory | Announcing the result of pending paraclinical tests | 4 |
|  | pathology |
|  | radiology |
|  | Time and place of next doctor appointment  | 5 |

 **Patient training form (by doctor and nurse, discharge time)**

Doctor’s signature: trainer’s (nurse) signature: Trainee’s (patient/companion) signature:

Time and date: Time and date Time and date