

# PERCEPTIONS OF CARE (INPATIENT/RESIDENTIAL VERSION)

**INSTRUCTIONS TO STAFF:** Please fill in the Site Code and respondent's Identification Number, one digit in each box. Fill in the Admission Date, Level of Care, Time Point, and Program type using the codes below.

Site code

Identification Number .....

Admission Date.....            
Month Day Year

Level of Care.... 1 = Inpatient      2 = Partial/Day Hospital      3 = Residential .....

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 received during your stay at this facility. We will use this information to improve our quality of care. Please fill in the circle that corresponds to your answer to each of the questions below. Please answer every question.

1. Did the staff give you information about the rules and policies of the program?..... Yes      ①      ②      No
2. Did the staff give you information about your rights as a patient?..... Yes      ①      ②      No
3. Did the staff tell you about the benefits and risks of the medication(s) you are taking? ..... Yes      ①      ②      ③ I am not taking any medication
4. Did the staff explain things in a way you could understand? ..... Never      ①      ②      ③      ④      Sometimes      Usually      Always
5. Were you involved as much as you wanted in decisions about your treatment? ..... ①      ②      ③      ④      Never      Sometimes      Usually      Always
6. How much did the staff involve your family involvement, in your treatment? ..... I wanted      ①      ②      ③      ④      More than      Less than      About the      No  
 I wanted      I wanted      right amount      which is what I wanted
7. Did the staff listen carefully to you? ..... Never      ①      ②      ③      ④      Sometimes      Usually      Always
8. Did the staff who treated you work well together as a team? ..... Never      ①      ②      ③      ④      Sometimes      Usually      Always

9. Did the staff spend enough time with you? ..... ① ② ③ ④  
Never Sometimes Usually Always
10. Did the staff treat you with respect and dignity? .... ① ② ③ ④  
Never Sometimes Usually Always
11. Did the staff give you reassurance and support?..... ① ② ③ ④  
Never Sometimes Usually Always
12. Did the staff review with you the plans for your continued treatment after you leave the program?. ① ② ③  
Yes Unsure No
13. Were you told whom to contact if you have a problem or crisis after you leave the program?..... ① ② ③  
Yes Unsure No
14. Did the staff tell you about self-help or support groups?..... ① ②  
Yes No
15. Did the staff give you information about how to reduce the chances of a relapse?..... ① ②  
Yes No
16. How much were you helped by the care you received?..... ① ② ③ ④  
Not at all Somewhat Quite a bit A great deal
17. Using any number from 1 to 10, what is your overall rating of the care you received in the program?..... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩  
Worst possible care Best possible care
18. Would you recommend this facility to someone else who needed mental health or substance abuse treatment?..... ① ② ③  
Yes Unsure No
19. Please fill in today's date..... 

MONTH		DAY		YEAR			

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

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

**YOUR OPINIONS ARE IMPORTANT TO US.**

7/30/2000

**THANK YOU VERY MUCH.**