

**McLaren Print System Order**

Order No: 7473  
 Order Date: 2014-12-03  
 User: Suzanne O'Brien  
 Phone: 810-342-2964

Ship Location: McLaren Flint / Sue OBrien Nursing Office  
 401 S. Ballenger Highway  
 Flint, MI 48532

**Forms**

Quantity: 500  
 Paragon Dept No: 91245  
 Dept Name: 91245  
 Company Number: 60

Order Total Price: 0.00

Item Number: M-28022  
 Item Description: Stroke Discharge Follow Up Survey  
 Revision Date:  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill:  
 Misc Info:

**Stroke Discharge Follow Up Survey**

**FLINT**

**Dear Patient,**

Thank you for the opportunity to care for you during your recent stroke admission to McLaren Flint. In order to provide the best possible care to our stroke patients, we would like to know what we are doing well and what needs improvement so we can better serve you in the future. Please take a moment to fill out the following questionnaire and return in the postage paid envelope.

1. Did you receive education regarding your stroke while in the hospital?      Yes   No
2. Is the written information about stroke helpful?                                      Yes   No
3. Do you feel the stroke education that you received while in the hospital was adequate for caring for yourself at home?                                      Yes   No
4. I understand the need to take the medications prescribed to reduce my risk of stroke/TIA.    Yes   No
5. Do you have a doctor's appointment for follow up-care?                                      Yes   No

If you answered "No" to any of the above questions and would like to speak with the Neuro-Stroke Coordinator please contact **Sue O'Brien** at (810) 342-2964.

6. How would you rate the care received by the following healthcare providers:

	Very Good	Good	Fair	Poor	Very Poor
Primary Care Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist (Stroke Doctor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Optional:** First and Last Name (please print): \_\_\_\_\_

Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Contact phone number: \_\_\_\_\_

*Thank you for your time in completing this questionnaire.*