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| **Patient Opinion Report** |

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| * Reporting Date (DD/MM/YY) 　　 　 / 　　 / | |
| * Reporter’s Name | * Job Title |
|  |  |

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| --- | --- | --- | --- | --- |
| * Patient Information | | | | |
| * SEX | * Age | | | |
| □　Male | □　Under 10 | □　10‘s | □　20‘s | □　30‘s |
| □　Female | □　40’s | □　50‘s | □　60‘s | □　Over 70 |

|  |  |  |  |
| --- | --- | --- | --- |
| * What is the patient's opinion on the matter?   Please select appropriate boxes. | | | |
| □　Cleaning | □　Hygiene | □　Foods | □　Equipment/Facilities |
| □　Maintenance | □　Staff’s attitude | □　Treatment/Care | □　Others |
| * Please describe more details in the box below. | | | |
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