



Dear Provider,

Thank you for collaborating with Mountain Valley Hospice (MVH) to provide hospice care for your patient.

For over 30 years, MVH has focused on serious illness so patients and their families can focus on living. To accomplish this, we need your help in identifying ways that we can better serve you and support your patients. Please take a few minutes to fill out this survey and return it as soon as possible. You may also access this survey on our website: [www.mvhcares.org](http://www.mvhcares.org). Click on "Providers" for the survey link. Please feel free to add any additional comments.

Thank you in advance for your help!

*Jacquelin Ross*  
*Director of Strategic Partnerships & Business Development*

**ADMISSIONS PROCESS**

1. How did your patient's referral/admission process to Mountain Valley Hospice work for you/your staff?

EXCELLENT     GOOD     SATISFACTORY     UNSATISFACTORY     N/A

What could we have done to improve the referral/admissions process for you/your staff?

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**COMMUNICATIONS**

2. How often did the MVH Team keep you informed about your patient(s) condition?

ALWAYS     USUALLY     SOMETIMES     NEVER     N/A

3. Did MVH provide timely information to you about your patient?     YES     NO     N/A

4. Did MVH provide appropriate information to you about your patient?     YES     NO     N/A

If no to either question 3 or 4, what kind of information could we have better provided and how often would you have liked to be contacted about your patient?

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4. Were communications between MVH and your staff professional and courteous?

ALWAYS     USUALLY     SOMETIMES     NEVER     N/A

**MEDICATIONS**

5. Based on the care your patient(s) received, how do you feel their pain was managed?

\_\_\_ WELL MANAGED \_\_\_ MANAGED \_\_\_ FAIRLY MANAGED \_\_\_ POORLY MANAGED \_\_\_ N/A

6. Were appropriate medication recommendations and doses requested by MVH staff?

\_\_\_ ALWAYS \_\_\_ USUALLY \_\_\_ SOMETIMES \_\_\_ NEVER \_\_\_ N/A

**CLINICAL CARE**

7. How do you feel that your patient’s physical symptoms were managed by our clinical staff while under MVH’s care?

\_\_\_ WELL MANAGED \_\_\_ MANAGED \_\_\_ FAIRLY MANAGED \_\_\_ POORLY MANAGED \_\_\_ N/A

8. Do you think MVH positively influences the quality of life for your patient and his/her family during end-of-life care?

\_\_\_ YES \_\_\_ NO

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

**GENERAL**

What was your overall satisfaction with the services provided by MVH?

\_\_\_ EXCELLENT \_\_\_ VERY GOOD \_\_\_ SATISFACTORY \_\_\_ POOR

What is the likelihood that you would refer future patients to MVH?

\_\_\_ DEFINITELY \_\_\_ VERY LIKELY \_\_\_ LIKELY \_\_\_ NOT LIKELY

Additional comments that would help us improve our services to you and your patient(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like to participate in a discussion about hospice care with our Medical Director Dr. Robert Brandis and MVH Clinical Staff? \_\_\_ YES \_\_\_ NO

*Optional Information:*

Name (Title) of Responder \_\_\_\_\_ Date: \_\_\_\_\_

Office/Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

THANK YOU SO MUCH FOR PARTICIPATING IN THIS SURVEY!

Please return via email at [Jacqualin.Ross@mvhcares.org](mailto:Jacqualin.Ross@mvhcares.org), by fax at (518) 773-2053 or by mail to Mountain Valley Hospice, 108 Steele Avenue, Gloversville, NY 12078

*Mountain Valley Hospice encourages its referring and attending physicians to voice concerns. Please contact Jacqualin Ross at any time at (518) 921-6694 or by email at [Jacqualin.Ross@mvhcares.org](mailto:Jacqualin.Ross@mvhcares.org)*