|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Case Info**  |  |  | **Anesthesia type** |  |
| **Date** |  |  | **Provider ID** |  |
| **MR #** |  |  | **CRNA ID** |  |
| **ASA Class** |  |  | **Additional provider** |  |

|  |  |
| --- | --- |
|  | Quality Rating |
| Strongly Positive | Somewhat | Neutral | Somewhat Negative | Strongly Negative | Don’t Know |
| How satisfied were you with your anesthetic care? |  |  |  |  |  |  |
| How likely are you to recommend the facility, personnel and anesthetic technique that you just underwent? |  |  |  |  |  |  |
| After you left the recovery room or returned home… |
| Did you experience nausea? | Yes  | No |
| Did you vomit at any time? | Yes  | No |
| How would you rate your pain on a scale of 1-10? (1 – no pain at all, 10 – worst pain ever |   |
| Has your pain medicine been effective | Yes  | No |
| Did you experience any unexpected events related to your procedure or the anesthetic? | Yes | No |

|  |  |
| --- | --- |
| If so, please explain… |  |