Telemedicine Program Satisfaction Survey
CONSULTING HEALTH CARE PROVIDER: STORE-FORWARD CONSULTATION

Name _____ Date _____ Specialty _____

Patient name: _____

Instructions:
Please rate the following on a scale of 1 to 6 where 1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, and 6 = strongly agree. Additional comments are appreciated. Thank you for your time.

Survey	Disagree					Agree
1. The quality of the image (focus, visual resolution, magnification) was acceptable.	1	2	3	4	5	6
2. The affected area was sufficiently visible/accessible. (If not, specify which areas were problematic).	1	2	3	4	5	6
3. Enough information was provided by the images selected	1	2	3	4	5	6
4. The inability to touch the affected area impaired diagnosis.	1	2	3	4	5	6
5. My communication with the referring health care provider was impaired by telemedicine.	1	2	3	4	5	6
6. The technology (the normal operation of the instrument rather than any problems encountered) distracted me from the diagnosis.	1	2	3	4	5	6
7. Technical difficulties made this process too time-consuming.	1	2	3	4	5	6
8. Diagnosis from digital images takes longer than traditional methods.	1	2	3	4	5	6
9. I am confident in my diagnosis .	1	2	3	4	5	6
10. I would have preferred to see this patient in person. arrangements, family, work, etc.).	1	2	3	4	5	6
11. Overall, I was satisfied with the consultation	1	2	3	4	5	6

Additional Comments: