**HARBOURSIDE FAMILY PRACTICE**

**Friends and Family Test**

Harbourside Family Practice would welcome your honest feedback to improve our service to you. Your answers will not be identifiable. Any comments will be included in full but we will attempt to remove any information that could identify you. Your response will be shared with our management team, Partners and Patient Participation Group.

You may be asked to complete the form more than once as the questions relate to your experience on the day you attend and this experience could be different on different days.

Once completed, please return the form to reception via SMS, email, post or in person to our post box to the left of the main entrance.

Thank you for your time.

**Thinking about Harbourside Family Practice, overall how was your experience of our service?**

Please tick as appropriate.

* Very good
* Good
* Neither good nor poor
* Poor
* Very poor
* Don’t know

**Please tell us about anything we could have done better.**

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Please continue on the back of the form if there is not enough room in this space.

Are you:

* Male
* Female
* Prefer not to say
* Prefer to self-describe …………………………………………………………………