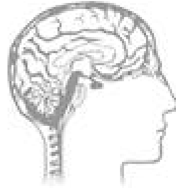

Dr M. Z. Ebrahim

MBChB(UCT), MMed Neurosurgery(SU), FC Neurosurgery(SA)

Neurosurgeon

Patient Feedback Form

Your feedback is important to us and we greatly appreciate you taking the time to complete this brief survey regarding your experience at our practice.

Name (Optional) ____

Date ____

On a scale of 1-5 (1–Poor, 5-Excellent), please rate your last visit with us in respect to the following:

1. Ease of setting your appointment

   1 2 3 4 5

2. Greeting by our receptionist

   1 2 3 4 5

3. Cleanliness & comfort of the waiting room

   1 2 3 4 5

4. Friendliness of Dr. Ebrahim

   1 2 3 4 5

5. Ability of Dr. Ebrahim

1 2 3 4 5

6. Overall quality of the service provided by us

1 2 3 4 5

7. Clarity of information given to you by Dr. Ebrahim

1 2 3 4 5

8. Degree to which your concerns were addressed by either our staff or Dr. Ebrahim

1 2 3 4 5

In your own words, please let us know any positive feedback you have for us regarding your experience or any concerns you may have about our services or practice.

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Are you are happy to have your comments shared on our website?

Yes ☐ No ☐

Any information submitted using this form is transmitted securely and held In the strictest of confidence, protecting your privacy.

Thank you for your feedback.