

GATEWAY
Referral Source Satisfaction Survey

Program _____ Date _____

Thank you for the opportunity to provide services to your Client/family recently. Please take a few moments to rate the following so that we may continue to improve our services. All surveys are confidential. CIRCLE ONLY ONE ANSWER

	Excellent	Good	Average	Poor	N/A
1. Services received matched client needs	1	2	3	4	0
2. Amount of communication I received from Gateway Staff	1	2	3	4	0
3. Availability of Gateway Staff	1	2	3	4	0
4. The client/family learned new skills that will be helpful in the future	1	2	3	4	0
5. Services received were informative & useful	1	2	3	4	0
6. I was given opportunities to participate in Treatment Planning for my Client/Family	1	2	3	4	0
7. The manner in which Gateway staff addressed safety concerns	1	2	3	4	0
8. Gateway's protection of Client's privacy and confidentiality	1	2	3	4	0
9. Possibility of future referrals to Gateway	1	2	3	4	0
10. Convenience/Accessibility of Locations	1	2	3	4	0

Please Circle which best describes your relationship with Gateway:

Physician/Hospital/Clinic Legal System DHR MH Treatment Facility Other Professional Educational System
 Other Community Resource Other Gateway Program EAP/Employer

ADDITIONAL COMMENTS: _____