Perceptions of Care (POC)
Inpatient Questionnaire

Instructions to Staff: Please fill in the following information completely.

Patient ID: __ __ __ __ __ __ __ __ __ __

Admission / Intake Date: __ __ /__ __/__ __

Level of Care:
- 1☐ Inpatient
- 2☐ Partial/day hospital
- 3☐ Residential

UserField1 (_____): __ __ __ __ __ __ __ __ __ __
UserField2 (_____): __ __ __ __ __ __ __ __ __ __
UserField3 (_____): __ __ __ __ __ __ __ __ __ __

Time Point:
- 1☐ Mid-treatment
- 2☐ Discharge termination
- 3☐ Post-treatment follow-up

Program Type (Select One):
- 1☐ General adult
- 2☐ Child/adolescent
- 3☐ Geriatric
- 4☐ Affective/mood disorders
- 5☐ Psychotic disorders
- 6☐ Anxiety disorders/trauma
- 7☐ Substance abuse/chemical dependency
- 8☐ Dual diagnosis
- 9☐ Other (fill in) _____

Instructions to Respondents:
We would like to know your views about the services you received during your stay at this facility. We will use this information to improve our quality of care. Please fill in the circle that corresponds to your answer to each of the questions below. Please answer every question.

1	Did the staff give you information about the rules and policies of the program?	**Yes** ☐	**No** ☐		
2	Did the staff give you information about your rights as a patient?	**Yes** ☐	**No** ☐		
3	Did the staff tell you what your medicine was for and its possible side effects?	**Yes** ☐	**No** ☐	**I am not taking any medication** ☐	
4	Did the staff explain things in a way you could understand?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
5	Were you involved as much as you wanted in decisions about your treatment?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
6	How much did the staff involve your family in your treatment?	**More than I wanted** ☐	**Less than I wanted** ☐	**About the right amount** ☐	**No involvement, which is what I wanted** ☐
7	Did the staff listen carefully to you?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
8	Did the staff who treated you work well together as a team?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
9	Did the staff spend enough time with you?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
10	Did the staff treat you with respect and dignity?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐
11	Did the staff give you reassurance and support?	**Never** ☐	**Sometimes** ☐	**Usually** ☐	**Always** ☐

12	Did the staff review with you the plans for your continued treatment after you leave the program?	Yes ☐	Unsure ☐	No ☐
13	Were you given instructions on what to do if you need help or have a crisis after discharge from the hospital (for example, calling your outpatient therapist or psychiatrist, going to an ER, etc.)?	Yes ☐	Unsure ☐	No ☐
14	Did the staff tell you about self-help or support groups?	Yes ☐	No ☐	
15	Did the staff give you information about how to reduce the chances of a relapse?	Yes ☐	No ☐	
16	How much were you helped by the care you received?	Not at all ☐	Somewhat ☐	Quite a bit ☐	A great deal ☐

17 Using any number from 1 to 10, what is your overall rating of the care you received in the program?

Worst Possible Care										Best Possible Care
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	1	2	3	4	5	6	7	8	9	10	

18	Would you recommend this facility to someone else who needed mental health or substance abuse treatment?	Yes ☐	Unsure ☐	No ☐
19	Were you satisfied with the cleanliness of the unit (for example, your room, the common areas, and the bathrooms)?	Never ☐	Sometimes ☐	Usually ☐	Always ☐
20	Were you satisfied with the food?	Never ☐	Sometimes ☐	Usually ☐	Always ☐
21	Were you satisfied with the Group Program?	Never ☐	Sometimes ☐	Usually ☐	Always ☐
22	Please fill in today's date.	Month /	Day /	Year

23. Please identify staff whom you feel deserve special recognition.

24. Is there anything else you would like to tell us about your care?

YOUR OPINIONS ARE IMPORTANT TO US.
THANK YOU VERY MUCH!

To Be Completed By Hospital Staff (OPTIONAL)

Primary Payer:
1☐ Self pay
2☐ BC/BS
3☐ Medicaid
4☐ Medicare
5☐ Commercial
6☐ Uninsured Primary payer:

Managed Care/HMO:
1☐ Yes
2☐ No
3☐ Unknown Managed Care/HMO:

Diagnosis	
GAF (1 to 100)	
Primary Diagnosis	
Secondary Diagnosis	
Tertiary Diagnosis	
AXIS IIa	
AXIS IIb	

Does patient have a medical condition requiring ongoing treatment?
1☐ Yes
2☐ No
3☐ Unknown

AXIS IV (Select all that apply):
1☐ Problems with primary support group
2☐ Problems related to the social environment
3☐ Educational problems
4☐ Occupational problems
5☐ Housing problems
6☐ Economic problems
7☐ Problems with access to health care services
8☐ Problems related to interaction with the legal system/crime
9☐ Other psychosocial and environmental problems
10☐ Not available