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*(Optional)*

Date of Service: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Please return this comment  
card to the Riverview Hospital  
front desk or mail it to:**

**Riverview Hospital  
Attn: Patient Advocate  
410 Dewey Street  
Wisconsin Rapids, WI 54494**

*Thank you for choosing...*

***Riverview***  
HOSPITAL

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# *Comment Card*

*How are  
we doing?*

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***Riverview***  
HOSPITAL

# *We Care How You Feel... about the care you received at Riverview*

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## *We Value Your Opinion*

We depend on you, our patients and other customers, to help us evaluate our services. To better serve you in the future, please let us know about your experience with us today. Be assured that we read all comments and work hard to address your concerns.

After you have filled out this form, **please turn it in at the hospital's front desk or the emergency/urgent care department's registration desk.** Or, if you prefer, mail it back to us later using one of the envelopes provided. The postage is already paid.

### *Which Riverview Hospital Association facility did you visit today?*

- Riverview Hospital
- Riverview Hospital Emergency Room
- Riverview Family Clinic  
Wisconsin Rapids
- Riverview Family Clinic - Nekoosa
- Riverview Family Clinic - Lakes
- Riverview Rehabilitation Center
- UW Cancer Center Riverview
- Riverview Community Dental Clinic

### *Which department(s) did you visit?*

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### *How would you rate the courtesy and personal manner of the staff?*

- Very Good    Good    Poor

Comments: \_\_\_\_\_

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### *How would you rate the overall quality of the care you received today?*

- Very Good    Good    Poor

Comments: \_\_\_\_\_

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### *What most impressed you during your visit today?*

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### *How can we improve?*

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### *Please feel free to make further comments on your visit today.*

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