

Name: _____

Date: _____

Shared Medical Appointment
Evaluation Form

How well were your medical needs met during today's medical appointment?

Not well					Very well
1	2	3	4	5	

Would you recommend this group to other patients?

Definitely not					Absolutely
1	2	3	4	5	

What went well today?

What could we do to improve the next Shared Medical Appointment?
