



Your opportunity to comment – Cottingham Medical Centre

We would like you to think about your recent experience of our service.

Date of your contact?
(What service given?)

(DD/MM/YYYY)

How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment?

(Please circle your choice below)

Extremely
likely

Likely

Neither likely
or unlikely

Unlikely

Extremely
unlikely

Don't know

Please tell us the main reason for choice:

.....
.....
.....
.....
.....

What is your gender?

(Please circle as appropriate)

Male

Female

What is your age?

(Please circle as appropriate)

16-24

25-34

35-44

45-54

55-64

65+

Do you have a disability?

(Please circle as appropriate)

Yes

No

What is your ethnic group?

(Prefer not to say? Leave Blank)

.....

Thank you for taking time to complete this form.

We welcome any suggestions for improvement, so please leave any comments below.

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.....
.....

Please return completed form to reception.

