

TELEHEALTH EVALUATION

(For Other than Patient or Consultant)

Please Submit Form by 15th of Following Month To:

Saint Elizabeth Foundation
 6900 L Street, Suite 100 * Lincoln, NE 68510
 Office: 402-219-7052 * Fax: 402-219-8979

The following items ask you to assess today's experience with telehealth. This is a required form to be filled out each time the network is used for something other than a patient consultation.

Originating Site: _____
 (Where your site is.)

Presenting Site: _____
 (Where the meeting chair or facilitator is located.)

Organization: _____
 (For whom you are working if other than the hospital)

Date: _____ **Time Began:** _____ **Time Ended:** _____

Number of people in attendance (at your location): _____

- 1.) What was your purpose in using the telehealth system?
- Administrative meeting Type: _____
 - Education/Distance Learning Topic: _____
 - Other (Please Specify): _____

- 2.) Why was the system chosen for this purpose?
- Saves travel time for self
 - Saves travel time for other persons
 - Only option
 - Other (Please Specify): _____

3.) Please Rate **PICTURE QUALITY?**

NOT SATISFIED		NEUTRAL		VERY SATISFIED	
1	2	3	4	5	

4.) Please Rate **SOUND QUALITY?**

NOT SATISFIED		NEUTRAL		VERY SATISFIED	
1	2	3	4	5	

5.) How likely are you to **use teleconferencing again** in the future?

NOT LIKELY		NEUTRAL		VERY LIKELY	
1	2	3	4	5	

Please give comments or suggestions regarding the telehealth service:

