



Quality Assurance Survey

AEVS Clinic: _____

Client Information:

Name/Number: _____

Client Number: _____

Address: _____

Patient Information:

Name: _____

Breed: _____

Age: _____

Sex: _____

Please complete the following questions for the patient listed above and for each case seen at AEVS. Please fax this survey to the AEVS business office at 952.746.5754. Your responses are appreciated and will assist us in better serving you, your clients, and their pets.

DATE _____ HOSPITAL _____

COMPLETED BY _____

1.) Is the detail and organization of the medical record satisfactory? Yes No

2.) Are you satisfied with the medical/ surgical management of your patient? Yes No

(If you responded "No" to any of the above questions, please explain in the comment section.)

Comments: _____

3.) Would you like a follow-up call on this case? Yes No

Phone number(s): _____

Email: _____

Please fax this survey to the Eden Prairie business office
FAX 952.746.5754