

## Paediatric Carers of Children Feedback form (PaedCCF)

Doctor's surname

Doctor's initials

Doctor's GMC number

Unique form number

Please **use black ink and put a cross** to indicate your choice(s) for each question e.g.  or write within the spaces provided. **Please base your answers on the consultation you have had today.**

	Not at all / least I would expect 1	Less than I would expect 2	Same as most doctors 3	More than I would expect 4	Best / most I would expect 5	N/A
1. <b>How much chance</b> were you given to discuss or do the things you wanted during the consultation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all / least I would expect 1	Less/worse than I would expect 2	About as much as average 3	More/better than I would expect 4	Completely / most I would expect 5	N/A
2. How well do you <b>understand your child's condition(s)</b> now you have seen the doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How well do you <b>understand your child's treatment(s)</b> now you have seen the doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How well did the doctor explain the <b>risks of your child's condition?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How well did the doctor explain the <b>risks of the treatment</b> of your child's condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>How confident</b> do you feel in looking after your child's medical condition(s) now you have seen the doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Worst / least I would expect 1	Less/worse than I would expect 2	Same as most doctors 3	More/better than I would expect 4	Best / most I would expect 5	N/A
7. How <b>good with your child</b> is this doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How <b>good with you</b> is this doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How much was the doctor interested in <b>your point of view</b> when he/she was asking questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How much was the doctor interested in <b>your point of view</b> when he/she was planning and explaining things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How much was the doctor interested in <b>your child's point of view?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. How well do you feel the doctor <b>listened</b> to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Worst / least I would expect 1	Less/worse than I would expect 2	Same as most doctors 3	More/better than I would expect 4	Best / most I would expect 5	N/A
13. How well do you think the doctor <b>understood</b> you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How well did the doctor <b>explain</b> things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. How much information did this <b>doctor give you on where you can find further information or support</b> available for you and your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. How well did the doctor <b>respect</b> your child's right to privacy, dignity and confidentiality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Overall, <b>how satisfied</b> are you with the doctor in this consultation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write in the space below if there is anything else you want to say on this consultation. Please print your feedback clearly.

Your Gender  Male  Female

Your ethnic group

<input type="checkbox"/> British	<input type="checkbox"/> Other White Background	<input type="checkbox"/> White and Asian	<input type="checkbox"/> White and African
<input type="checkbox"/> White and Caribbean	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other Black Background
<input type="checkbox"/> Indian	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese
<input type="checkbox"/> Other Asian Background	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Other ethnic group	<input type="checkbox"/> N/A

How many times have you seen the doctor before?  0  1-4  5-9  10+

What age is the child/young person? (enter age in completed years only)

If your child helped to complete this form, please check the box  No  Yes

It is really important for doctors to receive feedback on the care that they provide so that they can ensure that they are giving the care that families need. We are therefore grateful to you for taking the time to fill in this short form.

The information is entirely confidential and the doctor will not see the form. Your responses are combined with many other people's responses by the Royal College of Paediatrics and Child Health and fed back to the doctor anonymously.

**Thank you again for your help.**