River RADIOLOGY
Patient Focussed • Problem Oriented

P: (07) 839 1800 F: (07) 839 1810
E: care@riverradiology.co.nz W: www.riverradiology.co.nz
A: **Victoria Clinic**, 750 Victoria St, Hamilton 3204
A: **Hood St Clinic**, 30 Hood St, Hamilton 3204

Please return by fax or email to:
care@riverradiology.co.nz

Injection Audit Form

Patient Information

Name Date of Birth

We audit the effectiveness of our procedures. To aid us in this quality assurance we would greatly appreciate your help in completing this form.

Please fill in and post back in the stamped envelope provided, 2 months after your injection.

1. Please rank your pain PRE injection

No Pain Severe Pain

1 2 3 4 5 6 7 8 9 10

2. Please rank your pain 1 month AFTER injection

No Pain Severe Pain

1 2 3 4 5 6 7 8 9 10

3. Please rank your pain 2 month AFTER injection

No Pain Severe Pain

1 2 3 4 5 6 7 8 9 10

4. Please indicate your level of satisfaction (circle one only)

Very satisfied Satisfied Not Satisfied

5. Any other comments.