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| 1. **¿Cómo califica su experiencia global respecto a los servicios de salud, que ha recibido a través de la IPS?**  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **MUY BUENO** | **BUENO** | **REGULAR** | **MALA** | **MUY MALA** | **NO RESPONDE** | | 1. **¿Cómo califica la atención recibida?:**  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **PROFESIONAL** | **MUY BUENO** | **BUENO** | **REGULAR** | **MALA** | **MUY MALA** | **NO RESPONDE** | | **MEDICO** |  |  |  |  |  |  | | **ODONTOLOGO** |  |  |  |  |  |  | | **BACTERIOLOGO** |  |  |  |  |  |  | | **ENFERMERA** |  |  |  |  |  |  | | **FARMACIA** |  |  |  |  |  |  | | **SERVICIO AL CIUDADANO** |  |  |  |  |  |  | | **TECNICO RAYOS X** |  |  |  |  |  |  | |
| 1. **¿Recomendaría a sus familiares y amigos esta IPS?**  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **DEFINITIVAMENTE SI** | **PROBABLEMENTE SI** | **DEFINITIVAMENTE NO** | **PROBABLEMENTE NO** | **NO**  **RESPONDE** | |  |  |  |  |  | |
| 1. **¿la hora en la que fue asignada su cita, coincide con el momento de la atención?**   **NOO**  **SI** | **7. ¿Cómo califica las instalaciones físicas del centro de atención?**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **MUY BUENO** | **BUENO** | **REGULAR** | **MALA** | **MUY MALA** | **NO RESPONDE** | |
| 1. **¿Recibió usted información sobre su estado de salud y recomendaciones?**   **NOO**  **SI** | 1. **¿Conoce los derechos y deberes que tiene como paciente del Centro de Atención?**   **NOO**    **SI** |
| 1. **¿Volvería a utilizar nuestros servicios?**   **NOO**  **SI** | 1. **¿Conoce usted los mecanismos para manifestar sus inquietudes, reclamos, sugerencias o felicitaciones?**   **SI**  **NOO** |