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750 Victoria St, Hamilton 3204

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30 Hood St, Hamilton 3204

Please return by fax or email to:  
[care@riverradiology.co.nz](mailto: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 (tick one only)

Very satisfied

Satisfied

Not Satisfied

#### 5 Any other comments.

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.....  
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