

Telepsychiatry Session Feedback

Provider Name

Session Date

Overall Experience

☐

1

☐

2

☐

3

☐

4

☐

5

How comfortable did you feel communicating with the provider?

☐

1

☐

2

☐

3

☐

4

☐

5

Audio/Video Quality

☐

1

☐

2

☐

3

☐

4



5

What could be improved?

Additional Comments