**Familial Hypercholesterolaemia Project in Primary Care**

**Patient Evaluation Form**

Name of FH Specialist Nurse …………………………………………………………………………………………………………

1. Did this FH Patient Review service meet with your expectations?

Yes □ No □

Comments:

1. Is there anything that you feel could be improved about the service?

Yes □ No □

If yes, please state here what could be improved:

1. Please rate the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | Excellent | Very good | Good | Fair | Poor |
| The approachability of the FH Nurse Specialist who reviewed you in clinic  |   |   |   |   |   |
| The level of education provided by the FH Nurse Specialist |   |   |   |   |   |