PATIENT SATISFACTION SURVEY

Date:______________________________

Dear Patient,

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us.
Thank you.

Was your medications delivered on time?	❑ YES	❑ NO
Was the medications dispensed and delivered accurately?	❑ YES	❑ NO
Was the pharmacy training provided effective in educating you on your therapy?	❑ YES	❑ NO
Was the educational materials and instructions provided to you adequate to educate you on the medications dispensed to you?	❑ YES	❑ NO
Was the pharmacy staff courteous and helpful?	❑ YES	❑ NO
Was your financial responsibilities explained to you?	❑ YES	❑ NO
Did you receive advice or help from the pharmacy when needed?	❑ YES	❑ NO
Did the services provided make a positive mpact on the outcome of your care and/or therapy?	❑ YES	❑ NO
Would you recommend our pharmacy to your friends and family?	❑ YES	❑ NO
Did the services provided meet your needs and expectations?	❑ YES	❑ NO

COMMENTS (OPTIONAL)

Signature (optional)____

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