

## Med Quick Prescription Shoppe 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the medications dispensed and delivered accurately?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the pharmacy training provided effective in educating you on your therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the educational materials and instructions provided to you adequate to educate you on the medications dispensed to you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the pharmacy staff courteous and helpful?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was your financial responsibilities explained to you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you receive advice or help from the pharmacy when needed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided make a positive impact on the outcome of your care and/or therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you recommend our pharmacy to your friends and family?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided meet your needs and expectations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COMMENTS (OPTIONAL)

Signature (optional) \_\_\_\_\_

Form Revised: 04/01/2019