REFERRAL SATISFACTION SURVEY

Name (Optional):_____

City, State:_____

Date:_____

It is our desire to strive for excellence. In an effort to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and check the response that matches your experience.

Does the answering phone system meet your expectations? Do we answer the phone in a timely manner?	❑ YES	❑ NO	❑ N/A
Does the process for sending in a referral meet your expectations?	❑ YES	❑ NO	❑ N/A
Is the amount of information we request for a referral reasonable?	❑ YES	❑ NO	❑ N/A
Is the time spent on the phone when making a referral reasonable?	❑ YES	❑ NO	❑ N/A
Is our staff helpful and courteous?	❑ YES	❑ NO	❑ N/A
Is the quality, variety and availability of medications we carry adequate for your patient needs?	❑ YES	❑ NO	❑ N/A
Are you satisfied with the ease of calling in a referral / prescription?	❑ YES	❑ NO	❑ N/A
Is our geographic service area adequate to meet your referral needs?	❑ YES	❑ NO	❑ N/A
Is our clinical team responsive to your needs and requests?	❑ YES	❑ NO	❑ N/A
Would you recommend our services for family and friends?	❑ YES	❑ NO	❑ N/A
What can we do to earn more of your business?			

Comments: (Please comment on questions above that you marked no.)

Please return the survey to Med Quick Prescription Shoppe in the envelope provided. Thank you for choosing Med Quick Prescription Shoppe

Form Revised: 04/01/2019