CUSTOMER SATISFACTION SURVEY

Your feedback on this survey will help Our Infusion Pharmacy evaluate and improve services that you are currently receiving.

New Customer: ☐ Existing Customer: ☐

Patient Name: _____ Program: ☐ ☐
Binson's infusion services

Service Date: _____ Referral source : _____

Rate the level of quality:

	Excellent	Good	Fair	Poor
1. Medications were delivered as scheduled:	☐	☐	☐	☐
2. 100% of medications/Supplies were received as ordered:	☐	☐	☐	☐
3. Were you satisfied with the staff contacting you prior to filling your infusion needs?:	☐	☐	☐	☐
4. Personnel were courteous, prompt and professional on the phone	☐	☐	☐	☐
5. Your level of overall satisfaction with the pharmacy?	☐	☐	☐	☐

6. Was the nurse/Delivery personal professional and friendly: Yes or No
Comments if NO:

7. What recommendations do you have to improve the service that you received?

_____

_____

8 Comments: _____

_____

Completed By: _____

Follow-up Call Initial Date: _____ 2nd Call Date: _____ 3rd Call Date: _____

Survey Mailed Date: _____