InfuCare Rx

Satisfaction Survey

Respondent Name *(optional)*:	Date:

Respondent Type: ❑ Patient ❑ Caregiver ❑ Referral Source

Please complete this survey and mail it back to InfuCare Rx using the self-addressed stamped envelope provided or call us with your comments at (877) 822-9240. Your feedback is very important to us.

For each statement below, please circle the number next to each question that most closely describes how you feel about your specialty infusion pharmacy.

Dimension	Statement	Strongly Agree	Agree	Neutral or N/A	Disagree	Strongly Disagree
Care Planning	1. The process of starting or changing service was clear, including the clinical process and my financial responsibility.	5	4	3	2	1
Delivery	2. Products are delivered within the promised time frame in a professional manner.	5	4	3	2	1
Quality	3. The products, services and information I receive from the pharmacy work correctly and are of good quality.	5	4	3	2	1
Outcomes	4. The products and/or services I receive have the intended effect on the condition they are used to treat.	5	4	3	2	1
Clinical	5. Clinical pharmacy services have been to my satisfaction. *(Patient Management)*	5	4	3	2	1
Nursing	6. Nursing services provided have been to my satisfaction.	5	4	3	2	1
Communication	7. Employees are always polite, helpful, and easy to contact.	5	4	3	2	1
Satisfaction	8. I would recommend the pharmacy to others.	5	4	3	2	1

How can we improve our service to you?

Other Comments?

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