Partner Satisfaction Survey

Respondent Name (Optional): ______________________________	Date:

Respondent Type:	☐ Prescriber ☐ Referral Source ☐ Other (please specify): ____________________

For each statement below, please circle the number in each cell that most closely represents your experience with InfuCare Rx as an infusion and specialty pharmacy provider.

Dimension	Question	Very satisfied	Somewhat satisfied	Neutral or N/A	Somewhat dissatisfied	Very dissatisfied
Care planning	1. How satisfied are you with the process and ease of starting your patient on service with InfuCare Rx?	5	4	3	2	1
Delivery	2. How satisfied are you with the timeliness and accuracy of the delivery of products and services?	5	4	3	2	1
Quality	3. How do you feel about the safety and quality of care, products, and information delivered by InfuCare Rx?	5	4	3	2	1
Staff Responsiveness	4. How satisfied are you with the courteous and timely responsiveness of our staff to your inquiries?	5	4	3	2	1
Staff Knowledge	5. How would you rate our staff's knowledge regarding products and services we promote and provide?	5	4	3	2	1
Pharmacy Services	6. How satisfied are you with the clinical pharmacy services provided?	5	4	3	2	1
Nursing Services	7. How satisfied are you with the nursing care provided to your patients?	5	4	3	2	1
Communication	8. How would you rate the politeness, helpfulness, and ease of contacting staff members at InfuCare Rx?	5	4	3	2	1
Complaint Resolution	9. How satisfied are you with the timely and comprehensive manner for which your concerns are investigated and resolved ?	5	4	3	2	1
Satisfaction	10. How would you feel recommending InfuCare Rx to others?	5	4	3	2	1

11. How can we improve our service to you or your patients?

12. Other comments?

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