 **Patient Satisfaction Survey**

*Please rate from 1-5 with 5 being the highest* ***highest*** *l****owest***

**Clinical**

Pharmacist knowledge and professionalism: □5 □4 □3 □2 □1

Nurse’s compassion, concern and knowledge regarding □5 □4 □3 □2 □1

IV administration

Nursing visits were scheduled and on-time □5 □4 □3 □2 □1

Availability for Consultation □5 □4 □3 □2 □1

Educational Materials provided were helpful □5 □4 □3 □2 □1

and easy to understand

**Billing**

Explanation of financial responsibility prior to OR at the □5 □4 □3 □2 □1

start of therapy

Availability of Intake/Billing Personnel for questions □5 □4 □3 □2 □1

**Equipment and Delivery**

Timely delivery of medications and equipment □5 □4 □3 □2 □1

Equipment set-up and maintenance □5 □4 □3 □2 □1

**Overall Pharmacy Services**

If you received infusion in the pharmacy, your impression □5 □4 □3 □2 □1

on the staff, cleanliness and ambience

Overall pharmacy services rating □5 □4 □3 □2 □1

Will you recommend Las Vegas Infusion Pharmacy to □5 □4 □3 □2 □1

your family and friends

Please provide any additional comments below

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| --- |
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Signature above printed name

***Disclaimer: by signing your name above, you agree to have your feedback used anonymously by Las Vegas Infusion Pharmacy***