***St. Matthews Specialty Pharmacy***

***Local and Personal***

*p* 844-690-4462| *f* 844-524-HOPE(4673)

**PATIENT SATISFACTION SURVEY**

Dear Patient, Date:

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, take a few moments to tell us how we are doing. Please complete and mail it back to us. Thank you.

|  |  |  |
| --- | --- | --- |
| The medications (and supplies if applicable) were delivered on time | ❑ YES | ❑ NO |
| The medications (and supplies if applicable) were dispensed correctly | ❑ YES | ❑ NO |
| Training and consultations were effective in educating me or my caregiver on my service / care and /or therapy | ❑ YES | ❑ NO |
| Educational materials and instructions were adequate to educate me or my caregiver on the product(s) | ❑ YES | ❑ NO |
| The staff was courteous and helpful | ❑ YES | ❑ NO |
| My financial responsibilities were explained to me | ❑ YES | ❑ NO |
| I receive advice or help when needed | ❑ YES | ❑ NO |
| The services provided made a positive impact on the outcome of my care and/or therapy | ❑ YES | ❑ NO |
| I would recommend your service to my friends and family | ❑ YES | ❑ NO |
| The services provided met my needs and expectations | ❑ YES | ❑ NO |

How likely is it that you would use our specialty services to fill your future prescription needs? (please circle) Not at all likely Extremely Likely

0 1 2 3 4 5 6 7 8 9 10

How likely is it that you would recommend St. Matthews Specialty Pharmacy services to a friend or colleague?

Not at all likely Extremely Likely

0 1 2 3 4 5 6 7 8 9 10

COMMENTS (OPTIONAL):

Signature (optional):

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