National Infusion Services

Patient Perception of Care Survey

Therapy:________________

Patient Name(Optional):______________________

Performance improvement is an area that we continually monitor. Please complete the following survey and evaluate our services. This will allow us to make any necessary changes in the future to better service your needs. You can return the survey in the self-addressed stamped envelope.

Thank you.

Please rate the following areas of our service:	**Excellent**	**Good**	**Fair**	**Poor**
Customer Service: Rate our office and customer service staff based on their politeness and helpfulness.				
Pharmacist Service: Rate our Pharmacists knowledge, helpfulness and availability.				
Nursing Service: Rate the care provided by the nurse.				
Equipment and Supplies: Rate the quality of our equipment and supplies.				
Delivery Service: Rate the timeliness and efficiency of our delivery methods.				
Overall Service: Rate our overall service inclusive of all the above areas				

1. Did the Pharmacist and Nurse provide extensive teaching regarding your care? ❒Yes ❒No

Comments:____

2. Was there someone or something that made our service stand out? ❒Yes ❒No

Comments:____

3. Did you prefer having your health care at home / outpatient compared to a hospital? ❒Yes ❒No

4. If you need services in the future, would you choose National Infusion Services? ❒Yes ❒No

5. Please add any other additional comments here:______________________________

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