Patient Satisfaction Survey

Patient Name: _____

How Are We Doing?

We are committed to providing you with the best clinical experience possible, so we welcome any and all comments. Please take just a few moments to fill out this questionnaire, when finished please send it back in the pre-stamped envelope addressed to AvasaRx. Thank you!

Please rate the quality of the service you received from AvasaRx.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

I know how to contact AvasaRx for refills and other questions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disagree Agree

My medication was accurate and delivered in a timely manner.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disagree Agree

How likely are you to refer a friend or family member to AvasaRx?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never Always

Are pharmacy staff members…

Courteous? ☐ Yes | ☐ No

Informative? ☐ Yes | ☐ No

Effective and efficient? ☐ Yes | ☐ No

If you have any comments regarding AvasaRx, its staff and/or services, please write them here:

How frequently do you receive calls from our pharmacy?

☐ 3-5 times per month ☐ 1-2 times per month

☐ Once every 2 months ☐ Other

The information I received about my medication was helpful.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disagree Agree

By signing below, I authorize AvasaRx to use this information as a testimonial on our website.

Printed Name: _____

Signature: _____