National Distribution Facility

Our goal is to provide convenience, and satisfaction as well as the very best service to all our patients. We'd like to know how you feel about our patient-handling systems, and our pharmacists and staff members. Your comments will help us evaluate our operations to ensure that we are truly responsive to your needs. Thank you for your help.

PLEASE INDICATE THE PURPOSE OF YOUR MOST RECENT CALL:

☐ Prescription only ☐ Consultation

PLEASE RATE THE FOLLOWING:

A. YOUR CALL TO OUR SPECIALTY PHARMACY:	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
1. Your phone call answered promptly	5	4	3	2	1	N/A
2. Your ability to contact us after hours	5	4	3	2	1	N/A
3. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
4. Clear and concise phone communication	5	4	3	2	1	N/A
5. Your ability to obtain prescription refills	5	4	3	2	1	N/A
6. The professionalism of our call center staff	5	4	3	2	1	N/A
7. Availability of the on-call pharmacist or nurse (if applicable)	5	4	3	2	1	N/A
B. YOUR INTERACTION WITH THE CALL CENTER STAFF:						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The helpfulness of the person who took your call	5	4	3	2	1	N/A
3. Willingness to listen carefully to you	5	4	3	2	1	N/A
4. Taking time to answer your questions	5	4	3	2	1	N/A
5. Amount of time spent with you	5	4	3	2	1	N/A
6. Explaining things in a way you could understand	5	4	3	2	1	N/A
7. Instructions regarding your medication and next steps	5	4	3	2	1	N/A
8. Showing respect for what you had to say	5	4	3	2	1	N/A
9. Empathy and concern for your needs	5	4	3	2	1	N/A
10. Concern for your privacy	5	4	3	2	1	N/A
11. Knowledge of your health condition	5	4	3	2	1	N/A
12 Knowledge of your medication(s)	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU:						
1. Helpfulness of people who assisted you with billing/insurance	5	4	3	2	1	N/A
2. Promptness in resolving billing/insurance questions or problems	5	4	3	2	1	N/A
3. Effectiveness/helpfulness of our website	5	4	3	2	1	N/A

PLEASE COMPLETE THE OTHER SIDE ⟶

D. YOUR PRESCRIPTION:

1. Timeliness of the delivery of your prescription	5	4	3	2	1	N/A
2. Condition the prescription when received	5	4	3	2	1	N/A
3. Accuracy of your filled prescription	5	4	3	2	1	N/A
4. Keeping you informed of the prescription status	5	4	3	2	1	N/A
5. Promptness in resolving issues/questions concerning your prescription	5	4	3	2	1	N/A

E. YOUR OVERALL SATISFACTION:	Excellent	Very Good	Good	Fair	Poor
1. Our pharmacy	5	4	3	2	1
2. Our service	5	4	3	2	1
3. Your experience with our Specialty Pharmacy over other pharmacies you have used	5	4	3	2	1
4. Likelihood of using this pharmacy again?	5	4	3	2	1

IF NOT, PLEASE TELL US WHY:

_____

_____

5. Likelihood of recommending our pharmacy to family and friends?

0 1 2 3 4 5 6 7 8 9 10

Not at all likely (Please circle one) Extremely likely

IF NOT, PLEASE TELL US WHY:

_____

_____

What would have improved your experience using our Specialty Pharmacy?:

_____

_____

_____

_____

_____

Please provide any additional comments (optional)

_____

_____

_____

_____

_____

HOW DID YOU HEAR ABOUT US?

Physician	1
Friend or family member	2
Other:_____	3

Thanks very much for your help!

SullivanLuallin *Group*