National Community Oncology Dispensing Association, Inc.
PASSION FOR PATIENTS

< HealthCare Facility >
< Street >
< City, ST Zip >
< Phone >

Please take a few minutes to tell us how we can best meet our patient's needs.

Where do you get your **oncology** medication(s)? ❑ Pharmacy in doctor's office ❑ Mail-Order

Are you **required** to use a mail-order pharmacy for any of your medications?
❑ Yes ❑ No ❑ Don't Know

If yes, explain why? _____

Please rate the following areas for pharmacy type selected above:

	Very Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*	*Don't Know*
Convenience of receiving prescriptions	❑	❑	❑	❑	❑	❑
Time involved to receive prescriptions	❑	❑	❑	❑	❑	❑
Your interaction with the staff	❑	❑	❑	❑	❑	❑
General satisfaction	❑	❑	❑	❑	❑	❑

Has the pharmacy helped you with any co-pay/foundation assistance?
❑ Yes ❑ No ❑ Don't Know

If yes, how satisfied are you with the assistance you received?
❑ Very Dissatisfied ❑ Dissatisfied ❑ Neutral ❑ Satisfied ❑ Very Satisfied

Where would you **prefer** to fill your oncology medications?
❑ Pharmacy in doctor's office ❑ Mail-Order ❑ No preference

Please add additional comments or explanations to previous question(s). _____

_____

Gender: ❑ Female ❑ Male

Zip Code _____ Date _____