



**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 <i>Dissatisfied</i>	<i>Dissatisfied</i>	<i>Neutral</i>	<i>Satisfied</i>	Very <i>Satisfied</i>	<i>Don't Know</i>
Convenience of receiving prescriptions	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time involved to receive prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your interaction with the staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_

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