<Your practice name/logo here>

< Street > < City, State, Zip >

**Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

***Patient Satisfaction Survey***

**Please take a few minutes to help us best meet your needs.**

1. **Where do you receive your oral oncology medication(s)?**

❑ [Practice/Pharmacy Name] ❑ Mail-Order Pharmacy ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - 1. **Please provide feedback for where you receive your oral oncology medication(s):**

Not Applicable or Don’t Know

Very Dissatisfied

Very Satisfied

Neutral

Dissatisfied

Satisfied

**i.** Convenience of  ❑ ❑ ❑ ❑ ❑ ❑receiving prescriptions

**ii.** Length of time to ❑ ❑ ❑ ❑ ❑ ❑

obtain prescriptions

**iii.** Foundation assistance/ ❑ ❑ ❑ ❑ ❑ ❑

copay service from staff

**iv.** Clinical counselling ❑ ❑ ❑ ❑ ❑ ❑

(answering questions/  
providing education)

**v.** Pharmacy staff ❑ ❑ ❑ ❑ ❑ ❑  
communication

**vi.** Pharmacy staff ❑ ❑ ❑ ❑ ❑ ❑

professionalism

**vii.** Overall satisfaction ❑ ❑ ❑ ❑ ❑ ❑

1. **Where would you prefer to fill your oral oncology medications?**

❑ [Practice/Pharmacy Name] ❑ Mail-Order Pharmacy ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ No preference

1. **Have you ever used a mail-order pharmacy for any of your medications (oncology and non-oncology)?**

❑ Yes ❑ No ❑ Don’t Know

* 1. **If yes, please rate your overall satisfaction with mail-order pharmacy:**

❑ Very Satisfied ❑ Satisfied ❑ Neutral ❑ Dissatisfied ❑ Very Dissatisfied

1. **Please add additional comments or explanations to previous question(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_