REFERRAL SATISFACTION SURVEY

Name (Optional):______________________________

City, State:______________________________

Date:__________________

It is our desire to strive for excellence. In an effort to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and check the response that matches your experience.

Question			
Do we answer the phone in a timely manner?	❑ YES	❑ NO	❑ N/A
Does the process for sending in a referral meet your expectations?	❑ YES	❑ NO	❑ N/A
Is the amount of information we request for a referral reasonable?	❑ YES	❑ NO	❑ N/A
Is the time spent on the phone when making a referral reasonable?	❑ YES	❑ NO	❑ N/A
Is our staff is helpful and courteous?	❑ YES	❑ NO	❑ N/A
Are the quality, variety and availability of products we carry adequate for your patient needs?	❑ YES	❑ NO	❑ N/A
Are you satisfied with the ease of calling in a referral / prescription?	❑ YES	❑ NO	❑ N/A
Is our geographic service area adequate to meet your referral needs?	❑ YES	❑ NO	❑ N/A
Is our clinical team responsive to your needs and requests?	❑ YES	❑ NO	❑ N/A
Would you recommend our services for family and friends	❑ YES	❑ NO	❑ N/A
What can we do to earn more of your business?			

Comments: (Please comment on all entries above that you marked no.)

Please return the survey in the envelope provided. Thank you

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