PHYSICIAN SATISFACTION SURVEY

Name (optional):_____

City, state:_____

Date:_____

Thank you for allowing us to provide you Specialty Pharmacy services. 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. We value your comments and welcome any suggestions you may have to improve our services. It is our desire to strive for excellence.

Please Respond to the Following Service or Experience:	YES	No
I am satisfied with the services provided by Ocean Breeze	❑ YES	❑ NO
The telephone answering system meets your expectations. We answered the phone in a timely manner.	❑ YES	❑ NO
The process for sending in a referral meets your expectations.	❑ YES	❑ NO
The amount of information we request for a referral is reasonable.	❑ YES	❑ NO
The time spent on the telephone when making a referral is reasonable.	❑ YES	❑ NO
Our ability to dispense by the treatment day & dose (just in time delivery).	❑ YES	❑ NO
Our staff are helpful and courteous.	❑ YES	❑ NO
The quality, variety, and availability of medication we carry is adequate for your patient needs.	❑ YES	❑ NO
You are satisfied with the ease of calling in a referral/prescription.	❑ YES	❑ NO
Our geographic service area is adequate to meet your referral needs.	❑ YES	❑ NO
Our staff are responsive to your needs and requests.	❑ YES	❑ NO
Ocean Breeze took prompt action to resolve your needs and concerns.	❑ YES	❑ NO
You would recommend our services to other business associates.	❑ YES	❑ NO

What can we do to earn more of your business?

Please comment on all entries above that you marked “no”: