OMB No. 0915-0212
Exp Date 04/30/2009

National Marrow Donor Program®

Example of Customer Survey

OFFICE OF PATIENT ADVOCACY
Customer Satisfaction Survey

OPA SURVEY

1. How did you learn about OPA? *(Check as many as you need.)*

- ☐ Mail
- ☐ Phone call from OPA
- ☐ NMDP Web site (www.marrow.org)
- ☐ My doctor or nurse
- ☐ Other *(Please describe)* _____

2. Were you satisfied with the information or services from OPA? *(Check one.)*

☐ Yes ☐ Somewhat ☐ No ☐ Does not apply

3. What information or services did you ask for? *(Check as many as you need.)*

- ☐ Disease information
- ☐ Treatment information
- ☐ Stem cell transplant information
- ☐ How to find a volunteer unrelated donor
- ☐ Transplant Centers and doctors
- ☐ Understanding my insurance
- ☐ Financial help during treatment
- ☐ Help with travel and places to stay during transplant
- ☐ Tests of new treatments for my disease (clinical trials)
- ☐ I did not ask for information or services
- ☐ Other: *(please describe)* _____

4. Did you understand the information? *(Check one.)*

☐ Yes ☐ Somewhat ☐ Did not understand ☐ Does not apply

Comments: _____

5. Did you learn more about stem cell transplants after the phone call? *(Check one.)*

☐ Yes ☐ Somewhat ☐ Not at all ☐ Does not apply

Comments: _____

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6. Was the OPA person you spoke with friendly and polite? *(Check one.)*

☐ Yes ☐ Somewhat ☐ No ☐ Does not apply

Comments: _____

7. Do you (or the person you called about) think you will need a stem cell transplant now or in the future?

☐ **Yes** (If yes, what kind?)
- ☐ Using my own cells (autologous transplant)
- ☐ Using cells from a relative (related transplant)
- ☐ Using cells from someone who is not related to me (matched unrelated transplant)
- ☐ Using cells from an umbilical cord (cord blood unit)

☐ **No** (If no, why not?)
- ☐ I am on another therapy and doing well
- ☐ I don't have insurance or money to pay
- ☐ Other _____

☐ **I don't know**

8. If you have more comments or ideas for us, please include them here. _____

_____

_____

THANK YOU!

Please return the survey in the enclosed pre-paid envelope or mail to:

Office of Patient Advocacy
National Marrow Donor Program
3001 Broadway Street NE, Suite 500
Minneapolis, MN 55413