

# Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving our services. Your responses will be kept in confidence and only reviewed by our administrative staff.  
 Thank you for your time.

**Your Age:** \_\_\_\_\_ **How far did you travel to get here today?** \_\_\_\_\_

**Gender:**  **Male**  **Female**

**Type of Pharmacy Visit Today (please check one)**

- Clinic Visit with Medication**  
 **Pharmacy Clinic Appointment with Medication**  
 **Medication Refill**

**I decline to complete survey**  **why?** \_\_\_\_\_

<b>How do you rate...?</b> <i>(Please circle the appropriate number)</i>	<b>Excellent</b>	<b>Very Good</b>	<b>Fair</b>	<b>Poor</b>	<b>Very Poor</b>
1. The Pharmacy staff were nice and polite to me	5	4	3	2	1
2. The time spent waiting for medication or Pharmacy Clinic appointment.	5	4	3	2	1
3. The Pharmacy staff verified my identity (date of birth or chart number or ID card).	5	4	3	2	1
4. The Pharmacy staff's explanation of my medications was good and understandable	5	4	3	2	1
5. The amount of time spent with the Pharmacist.	5	4	3	2	1
6. The provider listened to you.	5	4	3	2	1
7. The pharmacy staff respected my privacy during consultation or visit.	5	4	3	2	1
8. Overall, the care I receive in the Pharmacy at Tohatchi Health Center meets my needs.	5	4	3	2	1
9. I have a provider that I think of as my personal doctor at Tohatchi Health Center.	5	4	3	2	1

**Do you have any suggestions or comments as to how we may better improve our services?**

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**Thank you for taking the time to complete this survey. Your opinion means a lot to us.**