

**WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER**  
**Pharmacy Department**

*The Anticoagulation Clinic Service kindly asks you to complete this survey. Please check the boxes that best indicate your opinion and give the form to the ACS pharmacist. Your responses will help us improve anticoagulation clinic services.*

DATE: \_\_\_\_\_

**Please check the answer that best agrees with your opinion.**

<i>Anticoagulation Clinic Services</i>	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>
I have a better understanding of my disease since I have been coming to this clinic.					
The pharmacists have been available to me when I needed help.					
The pharmacists provide care in a friendly and considerate manner.					
I feel comfortable knowing that the pharmacists are monitoring my disease.					
I feel that this clinic has improved my access to quality health care.					
I am satisfied with the care I receive by this clinic.					
The fingerstick INR blood testing in pharmacy has been just as convenient for me as the previous laboratory blood draw INR method.					
My appointments with the pharmacists have been on time (within 15 minutes on the actual appointment time).					
Please provide any additional comments that will help us to improve patient care in the Anticoagulation Clinic.					

*We appreciate your comments – Thank You!*



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