



Patient Satisfaction Survey

We are committed to providing excellent customer service. By completing this survey, you will be assisting us in improving our services to better care for our patients.

Please circle the number which best applies to your experience with us.

- | | YES | FAIR | NO |
|--|-------|------|----|
| 1. Was the equipment/service provided in a timely manner? | 1 | 2 | 3 |
| 2. Were you given complete instructions on your equipment/care? | 1 | 2 | 3 |
| 3. Were all your questions answered to your satisfaction? | 1 | 2 | 3 |
| 4. Was the staff courteous, knowledgeable and professional? | 1 | 2 | 3 |
| 5. Were you instructed on who/where to call with questions or problems? | 1 | 2 | 3 |
| 6. Were you satisfied with your equipment/service? | 1 | 2 | 3 |
| 7. Would you recommend our equipment/service to others? | 1 | 2 | 3 |
| 8. Were you given a copy of the Patient's Bill of Rights and Privacy Notice? | YES | | NO |
| 9. In your opinion, what could we improve to make your service satisfying? | _____ | | |

Which product(s) and service(s) did you receive? (Check all that apply)

- Medical Supplies
(Ostomy, Diabetic, etc.)
- Respiratory Equipment
(CPAP, BiPAP, oxygen, Nebulizer, etc.)
- Ambulatory Equipment
(walker, wheelchair, cane, etc.)

Other: _____

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