Ocean Breeze Healthcare

235 Dongan Hills Avenue, Suite 2B, Staten Island, NY 10305
(P) 800-219-5920 (F) 800-219-5921

Patient Satisfaction Survey:

Date:____________________________

Dear Patient,

You have recently received Pharmacy services from Ocean Breeze Healthcare. We are committed to meeting your needs and providing the highest quality service possible**.** In order to help us maintain our high standards, please take a few moments to complete this form and mail it back to us. Thank you.

Please return the questionnaire in the self-addressed, stamped envelope that is provided.

Please Respond to the Following Service or Experience:	YES	No
1. The staff was courteous and helpful.	❑ YES	❑ NO
2. The medications (and equipment / supplies if applicable) were delivered on time.	❑ YES	❑ NO
3. The medications (and equipment / supplies if applicable) were delivered / dispensed accurately.	❑ YES	❑ NO
4. Training and consultations were effective in educating me or my caregiver on my service/care and/or therapy.	❑ YES	❑ NO
5. Written educational materials and instructions provided were adequate.	❑ YES	❑ NO
6. The staff informed me of contact information during and after hours	❑ YES	❑ NO
7. The staff informed me of my rights and responsibilities and any financial obligation	❑ YES	❑ NO
8. The staff informed of who to contact if I had a concern/complaint or grievance	❑ YES	❑ NO
9. The pharmacist offered to counsel me on my medication	❑ YES	❑ NO
10. Pharmacist could be reached by telephone after hours and on weekends	❑ YES	❑ NO
11. The services provided made a positive impact on the outcome of my care and/or therapy.	❑ YES	❑ NO
12. I would recommend your service to my friends and family.	❑ YES	❑ NO
13. The services provided met my needs and expectations.	❑ YES	❑ NO

Please Respond To The Following:
14. Please share your suggestions to improve patient safety in the home and any other comments you would like to make.
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15. If you would like to receive a personal response to your additional comments, please complete the following information. Otherwise, this information is optional.

☐ Yes, please respond to my additional comments via mail or telephone as indicated below

Name____Telephone # ___________________________

Address____