INWOOD PHARMACY

4915 BRAODWAY
NEW YORK
NY 10034
TEL: 212-304-4646
FAX: 212-304-0759
Toll Free Number: 1-844-295-8203
EMAIL: inwoodpharma@gmail.com
Web: www.inwoodpharmacy.com

PATIENT SURVEY

Date:________________________

It is our desire to provide you with the best quality services available. In order to help us to maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us. Thank you.

My medications (or products) were delivered on time	❑ YES	❑ No
My medications (or products) delivered were dispensed accurately	❑ YES	❑ No
Training and consultations were effective in educating me or my caregiver on my service /care and / or therapy	❑ YES	❑ No
Educational materials and instructions were adequate to educate me or my caregiver on the medication(s) (or products) provided.	❑ YES	❑ No
The staff was courteous and helpful	❑ YES	❑ No
My financial responsibilities were explained to me	❑ YES	❑ No
I receive advice or help when needed	❑ YES	❑ No
The services provided made a positive impact on the outcome of my care and/or therapy	❑ YES	❑ No
I would recommend your service to my friends and family	❑ YES	❑ No
The services provided met my needs and expectations	❑ YES	❑ No

INWOOD PHARMACY

4915 BRAODWAY
NEW YORK
NY 10034
TEL: 212-304-4646
FAX: 212-304-0759
Toll Free Number: 1-844-295-8203
EMAIL: inwoodpharma@gmail.com
Web: www.inwoodpharmacy.com

Additional Feedback

Please list any areas in which our service could be improved.

Personal Information

First Name	Last Name	Gender	Age
Address	City	State	ZIP Code
Email	Phone		

Would you like someone to contact you regarding your responses on this survey?

☐ Yes | ☐ No

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.

Please return the completed survey to **Inwood Pharmacy** in the envelope provided. Thank you for choosing

Signature (OPTIONAL)