V-Care Pharmacy
Specialty + Medical & Surgical Supplies

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www.myVCarePharmacy.com

Physician Satisfaction Survey

V-Care Pharmacy always strives to improve the quality of the services that we provide to our physician and practice partners, as well as your patients. Thank you for taking a moment to complete this mini-survey. We truly value your feedback as it aids our ongoing quality improvement. Please fax the completed survey to 508-202-9343.

Name: _____ Practice/Hospital: _____
Email: _____ Phone: _____

Role: □ MD □ Practice Manager □ Nurse □ Case Manager □ Other (please specify)

	Please Rate the Following Service or Experience:	Excellent	Good	Average	Fair	Poor	N/A
1	Physician satisfaction with administration of specialty programs	5	4	3	2	1	N/A
2	Physician satisfaction with clinical content of specialty programs	5	4	3	2	1	N/A
3	Your contact/interaction with our Pharmacist(s)	5	4	3	2	1	N/A
4	Your contact/interaction with our Pharmacy associate	5	4	3	2	1	N/A
5	The speed & accuracy with which your order was processed	5	4	3	2	1	N/A
6	Our staff worked on the referral with a sense of urgency	5	4	3	2	1	N/A
7	The service level & helpfulness of our staff	5	4	3	2	1	N/A
8	The way in which your order & non-drug items (such as administrative supplies) were packaged	5	4	3	2	1	N/A
9	Our ability to dispense the medication to patients on time	5	4	3	2	1	N/A
10	The value of any clinical discussion/interaction you or your practice had with our Pharmacist(s).	5	4	3	2	1	N/A
11	The level of clinical expertise demonstrated by our Pharmacist(s).	5	4	3	2	1	N/A
12	Your satisfaction with our service as compared to other specialty pharmacy providers you may have used.	5	4	3	2	1	N/A
13	To the best of your knowledge, please rate your patients' experience with us.	5	4	3	2	1	N/A

	Please Respond To The Following
14	Why did you start referring to V-Care Pharmacy? (Please check all that apply) □ Heard of great services □ Health Plan requested □ Patient Requested □ Access to limited distribution drugs □ I/my practice reached out □ other_____
15	What services or capability would you like to see us add to make your experience even better? _____ _____ _____ _____ _____ _____
16	Would you recommend V-Care Pharmacy to your colleagues? □ Yes □ No (If No, why not? _____
17	If you have since stopped referring to V-Care Pharmacy, why did you stop? (Please check all that apply) □ Unhappy with service (What were you unhappy with? _____) □ You could not fill the order □ My patient was unhappy □ Prefer existing pharmacy □ Lack of drug I needed (Which drug? _____) □ Other_____