



Please complete and mail back with signed paperwork.

Exemplary Provider Satisfaction Measure

Patient: _____ Date of Service: _____

New Equipment: Wound Care Supplies

Access, Delivery and Service

Yes No NA

-
- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| 1. | Equipment/Supplies were delivered in a timely manner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Equipment/supplies was ready for patient use upon delivery. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Received and understood instructions on proper application and use of equipment/supplies. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Feel confident to operate/use equipment/supplies. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Received info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.
(Attached to Customer Copy.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Response to my questions, problems, concerns were addressed in a timely manner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Satisfied with the equipment or supplies. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Satisfied with the service. Would recommend to others? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | On a Scale From 1 to 5, 5 being the highest how would you rate our company? | | | |

1 2 3 4 5

Employee _____

Date of survey _____