Pharmacy Patient Survey

Thank you for choosing our pharmacy. Please take a moment to tell us about your experience. Fill the checkboxes completely using a blue or black pen. Your answers are anonymous.

Your experience today

How satisfied were you with each of the following?

Please cross one in each line

	Very dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very satisfied*
Waiting time for prescriptions	◯	◯	◯	◯	◯
Helpfulness of the pharmacy staff	◯	◯	◯	◯	◯
Clarity of medication advice	◯	◯	◯	◯	◯
Availability of the products you need	◯	◯	◯	◯	◯
Privacy when discussing your health	◯	◯	◯	◯	◯
Value for money	◯	◯	◯	◯	◯

Recommending us

How likely are you to recommend our pharmacy? *(Please cross one)*

- ◯ Very likely
- ◯ Likely
- ◯ Neutral
- ◯ Unlikely
- ◯ Very unlikely

Your comments

Any comments or suggestions?

Thank you for your feedback. Please return this form to the counter or the drop box.

To respond ⊗ or ●

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