SS MEDICAL SUPPLY

1-800-657-4090

PATIENT SATISFACTION SURVEY

Dear Valued Patient: ____ Date: ____________________

Phone: (_____) ________________________

Equipment / Products Delivered: ____

Was our company representative(s) courteous?	Yes	No	NA
Did the representative explain how to use all of the equipments?	Yes	No	NA
Are you comfortable with the use and safety of your equipment?	Yes	No	NA
Are there any other products or services you need that we can help you with?	Yes	No	NA
Do you have any questions or concerns? (If yes, please record question or concern and tell them you will Have someone call them. Fax, email, or call info to Intake Supervisor Or Management)	Yes	No	NA
Do you feel we were able to meet your needs and expectations? (If not, please comment below)	Yes	No	NA
Do you have any recommendations to help us improve our Products or services?	Yes	No	NA
Do you think you are likely to recommend SS Medical' products And services to someone else?	Yes	No	NA
If you need new equipment by your doctor's request, would you chose SS Medical Supply as your service provider? (If not, please comment below)	Yes	No	NA
Do you find useful the Tips for Preventing Falls?	Yes	No	NA

Thank you for your time. Have a Nice Day.

Would you please take a few minutes to describe what part of your experience with our service stood out?

We welcome any additional comments or recommendations you may have for us:

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Patient Signature