AMERICAN OUTCOMES MANAGEMENT, L.P.

Patient Satisfaction Survey

Please complete this suvey and return it in the enclosed envelope. Your satisfaction is very important to us.

5 = Strongly Agree 4 = Mostly Agree 3 = Neither Agree or Disagree
2 = Mostly Disagree 1 = Disagree N/A = Not Applicable

I received an introductory phone call from an AOM staff member prior to starting care.	(5)	4	3	2	1	N/A
The staff at AOM was courteous and helpful.	(5)	4	3	2	1	N/A
I was told who to call if I had problems with my intravenous (IV) medications.	(5)	4	3	2	1	N/A
Instructions were adequate to teach me or my caregiver how to give the intravenous medications.	(5)	4	3	2	1	N/A
The instructions were adequate for safe use of the equipment.	(5)	4	3	2	1	N/A
The equipment was clean and in good working order when delivered.	(5)	4	3	2	1	N/A
I had the supplies I needed to take my intravenous (IV) medications on time.	(5)	4	3	2	1	N/A
I was contacted prior to nursing visits and deliveries	(5)	4	3	2	1	N/A
I was satisfied with the response I received if I called on weekends or during evening hours.	(5)	4	3	2	1	N/A
My pain was adequately controlled most of the time (if applicable)	5	4	3	2	1	(N/A)
Patient rights and responsibilities were adequately explained to me.	(5)	4	3	2	1	N/A
My financial responsibility for my care was explained to me.	(5)	4	3	2	1	N/A
I received information about possible side effects caused by my intravenous (IV) medications.	(5)	4	3	2	1	N/A
The services provided met my needs and expectations.	(5)	4	3	2	1	N/A
I would recommend your service to my family and/or friends.	(5)	4	3	2	1	N/A

In an effort to provide safe and effective care, please tell us your suggestions, concerns or comments:

Joann, the nurse performing services, is excellent plus she's made it a pleasure to get my medication. A truly caring individual. Consider yourself very fortunate in having her represent you.

Name: (Optional) Date:

Check one ✓ Patient ____ Family Member ____ Caregiver MRN: ____