Exemplary Provider Satisfaction Measure ©

Patient: ______________________________ Date of Service: ________________

☐ New ☐ Existing Equipment: ____________________________

Access, Delivery and Service

	Yes	No	NA
1. Equipment/supplies was delivered in a timely manner.	☐	☐	☐
2. Equipment/suppies was ready for patient use upon delivery.	☐	☐	☐
3. Received and understood instructions on proper application and use of equipment/supplies.	☐	☐	☐
4. Feel confident to operate/use equipment/supplies.	☐	☐	☐
5. Received info on my Rights and Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	☐	☐	☐
6. Response to my questions, problems, concerns were addressed in a timely manner.	☐	☐	☐
7. Satisfied with the equipment or supplies.	☐	☐	☐
8. Satisfied with the service. Would recommend to others.	☐	☐	☐

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