SURVEY ABOUT CLINICAL PHARMACISTS IN PRIMARY CARE

A. DIRECTIONS FOR COMPLETING THE SURVEY:

1. Please complete the survey as best you can, being sure to answer ALL of the questions.
2. When asked about MEDICINES and MEDICAL PROBLEMS, please think about **only those that you see the clinic pharmacist for** (i.e.: blood thinner, diabetes, blood pressure, cholesterol, etc.)
3. Place the completed survey in the box on your way out of clinic.

B. Place one "X" in each row under the column that best describes **how well** you feel the pharmacist has done in each of the areas below over the **past year**. Remember when asked about MEDICINES and MEDICAL PROBLEMS, please think about **only those that you see the clinic pharmacist for.**

	Excellent	Very Good	Good	Fair	Poor
1. Told you the name of each of your medicines and what they are used for	☐	☐	☐	☐	☐
2. Explained what your medicines do	☐	☐	☐	☐	☐
3. Instructed you on how you should take your medicines	☐	☐	☐	☐	☐
4. Described the possible side effects of each of your medicines	☐	☐	☐	☐	☐
5. Provided information about your medical problems and the benefits of treating them	☐	☐	☐	☐	☐
6. Discussed goals of treatment for each of your medical problems	☐	☐	☐	☐	☐
7. Talked to you about the next steps in managing your medical problems	☐	☐	☐	☐	☐
8. Answered your questions fully	☐	☐	☐	☐	☐
9. Discussed the resources available to you to help you with your medications	☐	☐	☐	☐	☐
10. Spent plenty of time with you	☐	☐	☐	☐	☐
11. Talked to you in a way you could easily understand	☐	☐	☐	☐	☐
12. Treated you with respect and courtesy	☐	☐	☐	☐	☐
13. Rating of your clinical pharmacy visits overall	☐	☐	☐	☐	☐

C. Place one "X" in each box under the column that best describes **how important** you feel each of the areas below is to your health. When asked about MEDICINES and MEDICAL PROBLEMS, please think about **only those that you see the clinic pharmacist for.**

	Extremely Important	Very Important	Important	Somewhat Important	Not Important
1. Tells you the name of each of your medicines and what they are used for	☐	☐	☐	☐	☐
2. Explains what your medicines do	☐	☐	☐	☐	☐
3. Instructs you on how you should take your medicines	☐	☐	☐	☐	☐
4. Describes the possible side effects of each of your medicines	☐	☐	☐	☐	☐
5. Provides information about your medical problems and the benefits of treating them	☐	☐	☐	☐	☐
6. Discusses goals of treatment for each of your medical problems	☐	☐	☐	☐	☐
7. Talks to you about the next steps in managing your medical problems	☐	☐	☐	☐	☐
8. Answers your questions fully	☐	☐	☐	☐	☐
9. Discusses the resources available to you to help you with your medications	☐	☐	☐	☐	☐
10. Spends plenty of time with you	☐	☐	☐	☐	☐
11. Talks to you in a way you can easily understand	☐	☐	☐	☐	☐
12. Treats you with respect and courtesy	☐	☐	☐	☐	☐
13. Rating of your clinical pharmacy visits overall	☐	☐	☐	☐	☐
14. Of all the items asked about in questions 1 through 12, list the 3 which you value the most	1.		2.		3.

D. Please fill out the following information. If you are not comfortable providing an answer, simply skip the question and move on to the next.

DEMOGRAPHIC INFORMATION

1. What is your age?______
2. What is your gender? (circle one)
    a. Male   b. Female
3. What is your ethnicity? (circle one)
    a. Hispanic or Latino   b. Not Hispanic or Latino
4. What is your race? (circle one)
    a. American Indian or Alaska Native   b. Asian
    c. Black or African American   d. Native Hawaiian or Pacific Islander
    e. White
5. How many times in the past year have you met with the pharmacist one-on-one? (circle one)
    2   3-4   5-7   8-10   >10
7. What medical/prescription drug coverage do you currently have? (circle one)
    a. Institution-specific coverage   b. Medicaid/Medicare
    c. Private insurance   d. Cash/No third-party insurance coverage
8. How many total medications are you currently taking?_______
9. How many medications are managed directly by your pharmacist?_______
10. Which of the following disease states do you meet with the pharmacist about? (circle all that apply)
    a. Diabetes   b. Warfarin (Coumadin) management
    c. High blood pressure   d. Quitting smoking
    e. High cholesterol   f. Other reason: __________________________
11. How long have you had the problem(s) being managed by the pharmacist?
_______ (number of years)
12. Place where you worked with a pharmacist (name of clinic): _______________