CPAP NOW

Phone: (208) 287-1733 Fax: (208) 287-1734
support@cpapnow.com

PATIENT PERCEPTION OF CARE SURVEY

Please complete the following survey and return to CPAPnow.
We appreciate your business and input and look forward to continuing to serve you in the future.

1. Overall how would you rate the care and service you received from CPAPnow?
   _____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor

2. Would you recommend CPAPnow to others if they need similar equipment and services?
   _____ Yes _____ No

3. How would you rate the service you received from our Respiratory Therapist (RT)?
   _____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor

4. Was the Respiratory Therapist knowledgeable? _____ Yes _____ No

5. Did the Respiratory Therapist explain and demonstrate the proper set-up and use of your equipment?
   _____ Yes _____ No

6. Please provide us with any suggestions for improving patient care, safety and/or any other additional comments that you might have.

Optional: Name:_____ Date of Delivery: ___/___/___

Equipment Supplied: _____