PHARMACY ADMINISTERED FLU VACCINATION – PATIENT EXPERIENCE SURVEY

We would be very interested to know your views on this service.

Date of birth: ___________________ Date of Vaccination ________________

Please state the reason for having the vaccine (please tick)

Over 65 ☐ Chronic Respiratory Disease ☐ Chronic Kidney Disease ☐
Diabetes ☐ Chronic Heart Disease ☐ Immunosuppression ☐
Main Carer ☐ Chronic Neurological Disease ☐ Chronic Liver Disease ☐
Pregnant ☐ Longstay Residential Home ☐ Private ☐

1. Where did you get your Vaccine from last year?
   1st Time Vaccine ☐ Pharmacy ☐ GP ☐ Other ☐ ____________________

2. How satisfied were you with the service you received in the pharmacy?
   Extremely satisfied ☐ Very satisfied ☐ Satisfied ☐ Not Satisfied ☐

3. Was the flu vaccination administered as well by the pharmacist, as by other health care professionals in the past? e.g. GP or nurse?
   Yes ☐ No ☐

4. Do you feel that a pharmacy is an appropriate place to receive an immunisation?
   Yes ☐ No ☐

5. Would you use this service again in the future to receive your flu vaccination?
   Yes ☐ No ☐

6. Would you be happy to have other vaccinations administered by a pharmacist in the future?
   Yes ☐ No ☐

7. What did you like best about this service?
   Close to home ☐ No need for an appointment ☐
   Convenient opening times ☐ Convenient location near shops/work ☐
   Other ☐ Please State ____________________

8. How did you hear about this service?
   From pharmacist ☐ Poster in pharmacy ☐ Newspaper ☐
   From GP/Nurse ☐ Poster in surgery ☐ Word of mouth ☐
   Used it last year: ☐ Radio Advert ☐
   Other ☐ Please State ____________________

Many thanks for your time in completing this survey