LABLINK MEDICAL LABORATORY	Consultant Feedback Form	PRCS

1. Doctor's Particulars (Optional)

Name : ______________________

Specialty : ______________________

Clinic Address : ______________________

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Email : ______________________

Telephone No. : ______________________

Fax No. : ______________________

Doctor's Signature & Stamp:

2. Based on your experience with us, please help us to measure our current Quality of Services.
Please tick (✓) on the scale below to indicate your satisfaction; 1 (Poor) to 5 (Excellent) and N (Not Applicable).

Services	Onsite Laboratory						Medical Microbiology						Cytopathology						Histopathology						Molecular Diagnostic						TB Lab						General / Others					
Ratings	1	2	3	4	5	N	1	2	3	4	5	N	1	2	3	4	5	N	1	2	3	4	5	N	1	2	3	4	5	N	1	2	3	4	5	N	1	2	3	4	5	N
Report Format																																										
Turnaround Time (TAT)																																										
Pathologist Response																																										
Laboratory Staff Response																																										
Online result view																																										
Price																																										

3. **What new test would you like to be available at Lablink? (Please Suggest)**

4. **Any feedbacks that you wish to make?**

FOR INTERNAL USE
Comment/Review/Action taken:

Reviewed By	:	*(Public Relation & Marketing Services)*	*Verified By*	:	*(Quality Services)*
Name	:		*Name*	:	
Date	:		*Date*	:	