BUDLEIGH SALTERTON MEDICAL CENTRE

ACCESSIBLE INFORMATION NEEDS QUESTIONNAIRE

We wish to understand and record any particular communication needs you might have.

We will then do our best to meet your needs in all contacts with the surgery.

Full Name: …… Date of birth: ……

Address: ……..

Completed by patient / guardian / carer

If not the patient please state full name): ..……..……

Date Completed: ……

Is your communication with others affected by a health problem or disability which has lasted, or is expected to last, at least 12 months? YES / NO

If YES please complete the rest of the questionnaire - If NO you do not need to answer any other questions

What health problem or disability do you have?

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What is the best way for us to send you information?

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Do you need written information in a format other than standard print?

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What communication support could we provide for you at appointments?

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Can we share this information with other health and social care providers? YES / NO