KILLAMARSH MEDICAL PRACTICE

PARTNERS:
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Accessible Information Standard

We want to ensure that all communication we have with our patients is clear and set out in a way that is easy to understand. If you have a disability, impairment or sensory loss, please let us know how you would like us to communicate with you by completing this form.

Name:		**DOB:**
Do you have a specific condition that affects, or may affect, day to day communication? YES / NO		
Please **tick** preferred communication/ information method:		
☐	**Requires contact by telephone (XaYA0)** Telephone number……..	
☐	**Requires information verbally (XaPSq)**	
☐	**Requires contact via carer (Xad6e)** Carer's Name…… Carer's Contact number……..	**Does your carer have any communication needs?** YES/NO If yes, please advise ……
☐	**Requires contact by letter (Xabsd)**	
☐	**Requires contact by email (Xabse)** Email address……....	
☐	**Requires contact by short message service text message (Xabsc)**	
☐	**Requires written information in large format (XaPSp)** **14pt / 16pt / 18pt**	
☐	**Requires contact via telephone interpreting line (XaYAy)**	
☐	**Requires Interpreter for British Sign Language (XaLTC)**	
☐	**Please let us know if you need added support during your consultation** **Advocate / Carer (Ua2AK)** **Other** ……..	
☐	**Other (if we are able to offer in the future)** ……	
☐	**I do not have a preferred method of communication/information (Y17f3)**	

Please turn over to continue form

209 SHEFFIELD ROAD, KILLAMARSH, SHEFFIELD, S21 1DX
TEL 0114 251 0000
FAX 0114 248 9380

Consent to share with other Health Care Providers

To ensure that other health care professionals involved in your care are also able to support you with these needs, do we have your consent to share this information with them?	**YES/NO**

Consent for preferred method of contact

I confirm that I give consent for Killamarsh Medical Practice to contact me by my ticked preferred method of contact and consent to the extra information given above. I shall inform the Practice if my contact details change.

Signed:_____ **Date:** _____

Office use only: → Reception / Admin	Patients NHS number: _____		
Add READ code : **Y4523** Communication Questionnaire completed	Add Reminder to home screen: Stating their preferred communication / information method	Add relevant READ codes, for preferred communication / information method	Scan form on to patients medical record
(tick when completed)	(tick when completed)	(tick when completed)	(tick when completed)