**ACCESSIBLE INFORMATION FORM**

Name …………………………………………………………… Date of Birth ……………………………………

Please complete this form if you have a communication difficulty and need information in a different format. The receptionist or a member of the practice team will be happy to help you complete this.

Please tell us what is your disability: ………………………………………………………………………………..

**We want to know if:**

 Please tick those that you require

You need information in large text □

You need information in easy read □

Need a British Sign Language interpreter or advocate. □

We can support you to lip-read. □

You require the use of the induction loop for hearing. □

You require access to online appointments and prescriptions □

(this service requires two forms of I.D.)

You require information via letter/email or text message □

You require a look around the practice to make you feel □

more at ease when attending.

You would like to complete a Patient Passport (This is for □

those with Autism – this outlines things you prefer when

communicating with the staff)

You require somewhere quiet to wait for appointments □

Thank you for completing this form, we will record it in your records so we can take steps to ensure you receive the information you can access and understand and also receive any communication support you require.

Do you consent to the practice sharing this information with other healthcare providers (for example when you are referred to hospital)? Yes □ No □

Patient signature ………………………………………………………….. Date ……………………………..