**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 (9Nf4)**  Telephone number………………………………………….. Consent to leave messages on answer phone YES/NO | | |
|  | | **Requires information verbally (9Nf1)** | | |
|  | | **Requires contact via carer (9Nff)**  Carer’s Name………………………………………………………  Carer’s Contact number……………………………………… | **Does your carer have any communication needs?**  **YES/NO** | |
|  | | **Requires contact by letter (9NfQ)** | | |
|  | | **Requires contact by email (9NfR)**  Email address…………………………………………………………………………………………………..... | | |
|  | | **Requires written information in large format (9Nf0) 14pt / 16pt / 18pt** | | |
|  | | **Please let us know if you need added support during a consultation**  British Sign Language / Advocate / Carer present  Other …………………………………………………………………………………………………… | | |
|  | | **Other (if we are able to offer in the future)**  …………………………………………………………………………………………………… | | |
|  | **I do not have a preferred method of communication/information** | | | |

**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** |

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| --- |
| **I confirm that I give consent for Caritas GP Partnership 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: …………………………………..** |

**Consent for preferred method of contact**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Office use only: → | | | EMIS NUMBER: | | | |
| Add Alert of communication method | Record preferred method of contact | 389 code that been asked | | Record consent to tell other Healthcare providers | Record email consent 9Nds | Scan |