mid sussex health care
☎ **01273 834388**
www.midsussexhealthcare.co.uk

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?
(delete as appropriate)
YES(Xa4Cq)
NO(Xa4Cm)
If you have answered no please do not complete the rest of this form.

Please **tick** preferred communication/ information method:

☐	**Requires contact by telephone (XaYA0)** Telephone number…………………………………….. Consent to leave messages on answer phone YES/NO
☐	**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**

☐	**Requires contact by letter (Xabsd)**
☐	**Requires communications in 'easy read' format** (XaYB0)
☐	**Requires contact by email (Xabse)** Email address………………………………………………………………………………………….
☐	**Requires written information in large format** **20pt(Xacju)** **24pt(XacjV) 28pt(XacJW)**
☐	**Please let us know if you need added support during a consultation** British Sign Language (XaILE) / Advocate(Ua2AL) / Carer present (Ua2AJ) 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**

Consent for preferred method of contact

I confirm that I give consent for Mid Sussex Health Care Doctors 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:

Add Alert of communication method	Record preferred method of contact	Xa4Cq Record a need has been identified.	Record consent to tell other Healthcare providers Y3358	Record email consent XaRFI	Scan

July 2016