



BANKS AND BEARWOOD MEDICAL PRACTICE

DO YOU REQUIRE ANY EXTRA HELP WITH COMMUNICATION?

Name: ..... Date of Birth: .....

Address:.....

Phone Number /s.....

Do you use British Sign Language? YES  NO

Do you require a Sign Language interpreter? YES  NO

If yes, which type of Sign Language interpreter do you require?
.....

Do you lip read? YES  NO  Do you use a Lip Speaker? YES  NO

Do you use a Note Taker? YES  NO

If yes, please give details of type of note taker and if you require a speech to text reporter.
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Do you use a telecommunications device for the deaf? YES  NO

Do you use a deaf/blind intervener? YES  NO

Do you have a Legal Advocate\* or a Citizen Advocate\* to help you? YES  NO

If so, please give their details below:

Name: ..... Phone No: .....

\* Please delete as appropriate

Do you require an alert to be informed when it is your appointment time? YES  NO

If so, what type of alert? Audible  Visual  Tactile

How would you like to be contacted (please tick preferred option)?

Telephone       Text       Letter       Braille (Grade 1 or Grade 2? ..... )

Email       Please give your email address .....

If we are writing to you, please indicate which font size you require:

Font 12

Font 16

Font 20

Font 24

Font 28

Please give us any other details about difficulties you may have with communications and how we can assist you in the future.