**Accessible information Needs Questionnaire**

We wish to understand and record any particular communication needs you might have. We will then do our best to meet your needs in all contacts with the Practice.

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

Completed by Patient/guardian/carer Date completed: ….…………………………………………….

1. Is your communication with others affected by a health problem or disability which has lasted, or is expected to last, at least 12 months: **YES/NO** If **YES** please complete the rest of the questionnaire If **NO** you don’t need to answer any other questions.
2. What health problem or disability do you have? …………………………………………………………………….…………………………………….....................
3. What is the best way for us to send you information? ……….………………………………………………………………………………………………………………………
4. Do you need written information in a format or colour other than the standard format or colour? …………………………………………………………………………………………………
5. What communication support could we provide for you at appointments? …………………………………………………………………………………………………………………………….
6. Can we share this information with other health and social care providers? YES/NO