

Patient Information Sheet

All the information you provide is kept confidential

Please help us by completing the enclosed questionnaire.

If you need to read this in another language please ask at reception where a member of staff will be able to assist you.

NHS Westminster provides your local health services. Our mission is to ensure that patients in Westminster receive excellent healthcare.

We want to know..... what language(s) you speak, your ethnic group, your religion, any disability you may have, whether you are a student, in full time employment or retired, etc

We will use.....the information you give us to help us to plan better services and to provide personalised care for you and your family.

We will ensure..... all the information you give us will only be used by NHS Westminster and will not be passed on to anyone else and will only be used to improve health services for you in Westminster.

If you would like to obtain more information, please contact PALS (Patient Advice and Liaison Service) by calling 0800 587 8818 or 020 7150 8156.

Alternatively if you would like to obtain specific information about this questionnaire, please email Cynthia Chui, Equality & Diversity Officer on cynthia.chui@westminster-pct.nhs.uk

Thank you for taking time to complete this questionnaire and helping NHS Westminster to improve its quality of services.

Jezeli chcieliby Państwo otrzymało ten dokument w innym języku lub w innej formie albo jeśli potrzebna jest pomoc Umacza, to prosimy o kontakt z nami.

هذه الوثيقة متاحة باللغة العربية عند الطلب.

এই ডকুমেন্ট অনুরোধে বাংলায় পাওয়া যায়।

本文件可以應要求，製作成中文(繁體字)版本。

این مدرک در صورت درخواست به فارسی موجود است.

Este documento puede solicitarse en español.

Appendix 5

All the information you provide is confidential and will not affect your right to access any services in your practice. By completing this questionnaire you will be helping your GP and the Primary Care Trust to improve the healthcare services that are provided and so meet the needs of our population more effectively. You do not need to answer every question but please complete as much of this form as you can. The more information you provide, the more likely it is that we will be able to improve your service. All of the information collected will be used in aggregate to improve health services. anonymous!

If you need assistance completing this questionnaire, please ask a member of the practice staff.

Jezeli chcieliby Państwo otrzymał ten dokument w innym języku lub w innym formacie albo jeżeli potrzebna jest pomoc Umacza, to prosimy o kontakt z nami.

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Este documento puede solicitarse en español. Dokumentigaan waxaa lagu helaa Soomaali haddii la codsado.

Name (please print): _____ Male: Female:

Date of Birth: _____

Next of Kin/Emergency Contact: _____ Tel no. _____

Relationship to you: _____

Section A. Communication and Support

Language Support

What is your main preferred language? (Please specify) _____

Do you need an interpreter for your appointments? Yes No

If yes, would you prefer to have an interpreter of the same sex as yourself (if one was available)? Yes No

Do you need support with written English? Yes No

If so, please tick the box below that applies to you: I need written information

read to me in English an audio tape in large print in Braille Makaton

translated, please specify the language you need _____

Other Support

Do you consider yourself to have a disability that has a substantial effect on your ability to carry out normal day-to-day activities? Yes (please describe your disability) _____ No

Do you use anything to help with mobility, hearing or speaking? Yes No

If yes, please tick any of the lists below which apply to you:

I use a wheelchair a walking aid a hearing aid an advocate

hearing loop minicom British Sign Language

lip read other, please specify: _____

Section B. About Your Culture and Religious Identity

Which religion do you follow or practice? Please tick the box which applies to you

Buddhism Christianity (including Church of England, Catholic, Protestant, Methodist, Baptist)

Humanism Hinduism Jehovah's Witness Judaism Islam Sikhism

None Other religion, please specify _____

Section C. About your ethnic identity

To which of these ethnic groups do you feel you belong? Please tick the box which applies to you

ARAB or ARAB BRITISH

- Middle Eastern
- North African
- Any other, Please specify: _____

BLACK or BLACK BRITISH

- Black Caribbean
- Black African
- Any other Black background, please specify; _____

MIXED

- Mixed Asian
Please specify _____
- Mixed Black
Please specify _____
- Mixed White
Please specify _____
- Any other Mixed background
Please specify _____
- I do not wish to answer this question

ASIAN or ASIAN BRITISH

- Bangladeshi
- East African Asian
- Indian
- Pakistani
- Sri Lankan
- Tamil
- Any other Asian background, please specify; _____

WHITE or WHITE BRITISH

- English
- Irish
- Scottish
- Welsh
- Eastern European, Please Specify: _____
- Any other White Background,
Please specify, _____

OTHER or OTHER BRITISH ETHNIC GROUP

- Chinese
- Filipino
- Japanese
- Iranian
- Kurdish
- Vietnamese
- Other, Please specify _____

Section D. Other relevant information

In which country were you born? _____

Please tick any of the following which apply to you:

- | | | | | |
|-------------|--|--|--|---|
| I am | <input type="checkbox"/> a carer* | <input type="checkbox"/> cared for | <input type="checkbox"/> a refugee | <input type="checkbox"/> an asylum seeker |
| | <input type="checkbox"/> homeless** | <input type="checkbox"/> in full time employment | <input type="checkbox"/> self-employed | <input type="checkbox"/> Housebound |
| | <input type="checkbox"/> in part-time employment | <input type="checkbox"/> unemployed | <input type="checkbox"/> student | <input type="checkbox"/> retired |
| | <input type="checkbox"/> homemaker/housewife | | | |

* A carer is someone who cares for or looks after somebody who needs support because of a physical or mental disability, long term illness or physical frailty and does this for more than 14 hours per week. This includes caring for a child with special needs.

** You do not have permanent accommodation

I understand and give consent that this information will only be used by my GP and NHS Westminster for healthcare planning purposes.

Signed _____

Name _____

Date _____

Thank you for your time