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| **Your Accessibility Needs** |
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| We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know. |
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| **Your Details** |  |
|  |  |  |  |  |
| Title: | Choose an item. |  | Enter other title |  | Surname: | Enter Surname….. |
|  |  |  |  |  |
| Date of Birth: | Choose the date. |  |  | 1st Names: | Enter 1st Names….. |
|  |  |  |  |
| Home Address: | Enter full address |  |  | Preferred Tel: |       |
|  |  |  |  |
|  |  |  |  |  |  |
| Post Code: | Enter Post Code. |  |  |  |  |
|  |
| **Please tell us what communication requirements you have (eg. braile, large print, etc):** |
|  |
| Enter text here. |