

# Upwell Street Survey Questionnaire

Please help us improve services by answering the following questions

## **WHICH THREE AREAS CONCERN YOU MOST ?**

Please TICK THREE from the list 1 – 7 below

1. Telephone advice from a doctor or nurse

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2. Cleanliness of the practice

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3. Opening times of the surgery

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4. Out of Hours service (deputising)

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5. How staff should contact you

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6. Getting an appointment

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7. Quality of care provided by Doctors and Nurses

**ANY OTHER CONCERNS ? Please give brief details below**

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**Please now turn over the page**

# ARE YOU AWARE THAT WE PROVIDE THE FOLLOWING SERVICES ?

Tick ✓ Yes or No

Online Prescription Ordering/ Online Appointments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Electronic Prescribing – * new from 5 March 2014	Yes <input type="checkbox"/> No <input type="checkbox"/>
Text Messaging Service	Yes <input type="checkbox"/> No <input type="checkbox"/>
Minor surgery (wart clinic, soft tissue & joint injections)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chiropody for diabetic patients - by GP referral only	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flu vaccination clinics in October and November each year.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Health Reviews	Yes <input type="checkbox"/> No <input type="checkbox"/>
Women’s Health Reviews including Menopause	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arrange Physiotherapy - by GP referral only	Yes <input type="checkbox"/> No <input type="checkbox"/>
Travel advice and injections – (Not Yellow Fever)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Well baby clinics for advice and injections	Yes <input type="checkbox"/> No <input type="checkbox"/>
Well person checks and general screening – includes BP Check, height, weight, smear testing.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contraception & Sexual Health	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emergency contraception - fully confidential service.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Counsellor - by GP referral only	Yes <input type="checkbox"/> No <input type="checkbox"/>
Smoking Cessation Advice including one-to-one advice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Elderly Over 75 check	Yes <input type="checkbox"/> No <input type="checkbox"/>
Care Planning for patients	Yes <input type="checkbox"/> No <input type="checkbox"/>

**ARE THERE OTHER SERVICES YOU WOULD LIKE US TO PROVIDE ? - If yes please say below**

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<b>PLEASE NOW ANSWER THE TWO QUESTIONS BELOW</b>	<b>Tick ✓ as appropriate</b>
1. Would you like to speak to the practice manager about any of the points you have made above	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Would you like to come to the next patient participation group meeting (see notice in surgery)	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If you ticked yes to either of the above questions Please give your name and contact details below</b> <b>Name:</b> <b>Telephone :</b>	

**Thank you for taking the time to complete this questionnaire. Please hand your completed questionnaire back into reception. We will notify patients of the results of this survey some time during March 2014**