**The Pendle Medical Partnership and Colne Family Doctors**

**Patient Questionnaire**

Please find below a patient questionnaire regarding the proposed joining of The Pendle Medical Partnership and Colne Family Doctors. Please leave your details at the end of this form if you would to be contacted by either of our Practice Managers.

1. **How often do you use our Practice services?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Every Week | At least every month | At least once a year | Never |
| Repeat Prescriptions |  |  |  |  |
| Nurses |  |  |  |  |
| Healthcare Assistants |  |  |  |  |
| Doctors |  |  |  |  |
| Pharmacist |  |  |  |  |
| Advanced Nurse Practitioners |  |  |  |  |
|  |  |  |  |  |

1. **How do you feel about the level of information that you have received about the proposed merger?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Very Well Informed | Informed | Neutral | Not Informed | Poorly Informed |
|  |  |  |  |  |

Please tell us what other information you think you may need?

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

1. **Which of the following are the most important to you if the proposed changes go ahead?**

 (please rate in order of importance with 1 being the most important to you)

|  |  |
| --- | --- |
| Access to a male GP |  |
| Access to a female GP |  |
| Access to a Nurse for long –term conditions |  |
| Access to a Nurse Practitioner |  |
| Access to a Health Care Assistant |  |
| Access to a Practice Pharmacist |  |
| Access to telephone consultations |  |
| Access to collect prescriptions |  |

1. **Do you need to be seen at either Colne or Earby surgeries, or are you happy to be seen at either site**?

………………………………………………………………………………………………………………………………………………

1. **What improvements would you like to see happen as a result of the proposed changes and are there any considerations you would like us to make?**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

1. **Having read the information how do you feel about the proposed changes?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|  |  |  |  |  |

Please tell us why you feel this way

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

1. **Do you have any further comments, concerns or suggestions that you would like to add regarding our proposed changes?**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

If you would like to be contacted by our Practice Managers from either site, please leave your name and contact details below.

………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………….