

**Patient Member Registration Form**

Thank you for your interest in becoming one of our Patient Members and joining

our “Your Health, Your Voice” Programme!

1. Tell us how involved you would like to be – you can change your mind at any time

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| --- | --- |
| **Level of involvement** | **What to expect** |
| **Low involvement** | Receiving newsletters, occasional surveys, hearing about our events etc... |
| **High involvement** | Low involvement plus contributing to and/or attending occasional meetings and focus groups |

1. Do you have an interest or experience in any of the following areas?

You can tick as few or as many as you like

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| --- |
| Area of interest |
| All |
| GP Services |
| Hospital Services |
| Community Services  (e.g. district nursing) |
| Long Term Conditions  (e.g. diabetes, COPD) |
| Healthy Lifestyles (e.g. stopping smoking, weight management) |
| Mental Health |
| End of life care |
| Continuing healthcare (CHC) |
| None/I don’t want to disclose |

|  |
| --- |
| Area of interest |
| Dementia |
| Children’s & maternity services |
| Older people’s services |
| Urgent and emergency care  (e.g. NHS111 & A&E) |
| Cancer |
| Physical disabilities |
| Learning disabilities |
| Alcohol & drugs misuse |
| Sexual Health |
| Other (please state) |

Other .....................................................................................................................................................

1. Which GP Surgery are you registered with?
2. Would you like to join your GP surgery’s Patient Group? Yes No Already Joined

If yes, we will pass your details onto your surgery’s group, if there is not currently a patient group established, we will let the surgery know there is interest. If you don’t want us to do this please tick ‘No’.

1. Do you consider yourself to have a disability?

Yes No Don’t wish to disclose

If yes please state

1. Do you have any children under 18 living with you for all or part of the time?

Yes No Don’t wish to disclose

1. Do you look after an elderly person, or someone with a disability, either at your home or elsewhere?

Yes No Don’t wish to disclose

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**Contact details**

**Title Mr/Mrs/Ms/Miss/Dr/Prof Other**

**First Name** ....................................................................... **Last Name**......................................................................

We will use email as our primary method of communication – other leaflets and information will be made available as usual

**Email address**..........................................................................................................................................................

**Address**....................................................................................................................................................................

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..................................................................................... **Postcode**...........................................................................

**Gender**  Female Male I don’t wish to disclose

**Ethnic Origin** White British White – Other White – Gypsy or Irish Traveller

Asian – Asian British Black – African Caribbean Black – British

Mixed Ethnicity Other Ethnic Group

I don’t wish to disclose

**Year of Birth**............................................................ I don’t wish to disclose

**You can complete this form online or return to your NHS Solihull GP Surgery. Alternatively post your form to NHS Solihull CCG, Friars Gate, Stratford Road, Solihull, B90 4BN**