

Surgery Pre-Installation Questionnaire

Section A: Practice Details *(Please complete in block capitals)*

Practice Name:	
Address 1:	
Town:	
County:	
Postcode:	
Telephone Number:	
Fax Number:	

Section B: Contact Details *(Only used with regards to rack)*

Contact Name:	
Position:	
Email address:	
Tel No:	

Section C: Surgery Details

In the boxes provided please enter the number of the following in your surgery.

Doctors: Nurses: Nurse prescribers:

What clinics are currently run in your surgery and what quantities of patients

subscribe to these? *(Please tick as appropriate and write the quantity below each clinic type.)*

Allergy: Diabetes: Travel Clinic:

Anti-Smoking: Nutrition & Diet: Vaccination:

Asthma: Heart Health:** Well Man:

Baby Clinic:* STD: Well Woman:

* Includes Ante-Natal, Child Health/Illness, Family Planning and Maternity.

** Includes Blood Pressure.

How Many Registered Patients do you have? _____

Is There a particular demographic lending (Age) ? *(Please tick as appropriate.)*

18-29 30-39 40-49 50-59 60+

What are your surgery access hours? *(Please enter the times we can gain access to the site)*

Open AM:	<input type="text"/>	Close AM:	<input type="text"/>
Open PM:	<input type="text"/>	Close PM:	<input type="text"/>

Half Days / Regular Closures
(Please state days and times)

Section E: Other

Please provide further information that may be relevant in the space provided, if necessary attach information using a separate sheet.

If you require additional questionnaires, or have any queries please contact W.I.S on 01489 860000.