




We would like you to think about your recent experiences of our service.

How likely are you to recommend our GP practice to friends & family if they needed similar care or treatment?




 Extremely likely <input type="checkbox"/> Likely <input type="checkbox"/>  Please tell us what we are doing well	 Neither likely nor unlikely <input type="checkbox"/>  Please tell us why?	 Unlikely <input type="checkbox"/> Extremely unlikely <input type="checkbox"/>  Please tell us how we can improve?
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Don't know

Please write comments overleaf

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Thank you for helping us improve our services

What are we doing well? .....

.....

How can we improve? .....

.....

Please provide contact details if you would be happy for us to get in touch:

Name ..... Tel/Email .....

<b>What is your sex?</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>What age are you?</b> <input type="checkbox"/> 0-15 <input type="checkbox"/> 55-64 <input type="checkbox"/> 16-24 <input type="checkbox"/> 65-74 <input type="checkbox"/> 25-34 <input type="checkbox"/> 75-84 <input type="checkbox"/> 35-44 <input type="checkbox"/> 85 + <input type="checkbox"/> 45-54
<b>What is your ethnic group?</b> <input type="checkbox"/> White <input type="checkbox"/> Mixed/Multiple ethnic groups <input type="checkbox"/> Asian/Asian British <input type="checkbox"/> Black/African/Caribbean/Black British <input type="checkbox"/> Other ethnic group	<b>Are your day-to-day activities limited because of a health problem or disability?</b> <input type="checkbox"/> Yes, limited a lot <input type="checkbox"/> No <input type="checkbox"/> Yes, limited a little <input type="checkbox"/> Rather not say

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