**GENERAL PRACTICE SERVICE QUESTIONNAIRE**

**Provider Information**

1. Practice name:-
2. Integrated Care Community:-
3. Practice contact for PH services (name/ title):-
4. Main address:
5. Telephone:-
6. E-mail:

**Service Information**

Please answer the questions below:-

|  |  |
| --- | --- |
| 1. Please indicate which services you wish to provide:-
 | Yes/No |
| Lot 1: Delivery of the national NHS Health Check programme to registered patients |  |
| Lot 2: Screening and treatment of asymptomatic STI ( Level 1) |  |
| Lot 3: Assessment and treatment of symptomatic STI (Level 2) |  |
| Lot 4: Insertion and removal of contraceptive hormonal implants |  |
| Lot 5: Insertion and removal of intra-uterine contraceptive devices/systems (IUCD/S) |  |

|  |  |
| --- | --- |
|  | Yes /No |
| 1. Will all staff providing these services meet the competency requirements outlined in service specifications?
 |  |
| 1. Will the provider meet the quality requirements outlined in service specifications?
 |  |

**Delivery locations**

1. Please list all fixed sites that you provide services from and indicate which services you wish to provide from each location (please insert additional rows if required).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Site address | Practice Code (if applicable) | NHS Health Checks | Level 1 STI | Level 2 STI | Implants | IUCD/S |
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|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | **Yes /No** |
| 1. Will any of these services be provided for patients from any other practice?
 |  |
| If YES, please indicate which services will be provided and to which practice patients:- |

1. If providing Tier 2 STI services, please provide contact details of the Sexual Health lead in the practice:-

|  |  |  |
| --- | --- | --- |
| Name | Job title | email |
|  |  |  |

1. If providing IUD/S, please list the members of staff who will be providing this service (please add additional rows if required):-

|  |  |  |
| --- | --- | --- |
| Name | Job title | Date Letter of Competence acquired\* |
|  |  |  |
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|  |  |  |
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1. If providing contraceptive implants, please list the members of staff who will be providing this service (please add additional rows if required):-

|  |  |  |
| --- | --- | --- |
| Name | Job title | Date Letter of Competence acquired\* |
|  |  |  |
|  |  |  |
|  |  |  |
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\*The Provider should be able to provide copies of Letters of Competence if requested by the Council