

Centre Facilities Questionnaire

Please answer all questions and fax or email to the above number or email address.

We will enter all details onto our database which will ensure we only send the medicals to you if you have the appropriate facilities.

A separate questionnaire for individual doctors is enclosed, please feel free to photocopy as many as you need for each participating doctor.

There are occasions where we may just require blood pressure readings, height and weight, we are happy for a nurse to carry this out providing we have a completed questionnaire for the nurse.

Centre Name:

Address:

(If different from above)

Payment Name: _____

Address: _____

_____ p/code _____

Can we reimburse you by bacs? yes no
(if yes, we will contact you for further details)

Who should we contact to book a medical Name _____

Practice Manager name: _____

Contact number: Office _____ Mobile _____

Fax _____ email _____

Web site address _____

(delete as required)

Best description of your centre: a) *Private / NHS* b) *Private*

Best description of location: a) *Residential* b) *Town Centre* c) *City centre*

Approximate age of centre: a) *Under 10years* b) *10-25 years* c) *Over 25 years*

Do you have car parking?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you carry out insurance medicals?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you carry out pre-employment medicals?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you carry out health screening?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you have on-line appointment booking facility?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you carry out medico legal work?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you carry out home/work visits if required?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you have disabled facilities?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

What days and times of the week are allocated for the above screenings? *(Please list below)*

What is the best time to call for booking an appointment? _____

Resting ECG	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Exercise ECG										
	<i>Treadmill</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
	<i>Cycle</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Spirometry	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Audiometric	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
	<i>Sound Proof Room</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Does your audiometric testing comply with HSE regulatory screening standard MS26 <i>(if unsure please telephone our office)</i>				yes	<input type="checkbox"/>	no	<input type="checkbox"/>			
Centrifuge	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Ishihari Colour Cards	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(onsite)</i>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	
Bio-impedance analysis	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	<i>(method)</i>	_____				