

Telephone Consultation Questionnaire (TCQ)

Application Forms

Please complete in BLOCK CAPITALS

Step 1 Fill in your details	Step 2 Clinicians	Step 3 Price Guide
Practice manager or contact name:	(Dr/Mr/Mrs/Ms/Miss)	
Practice name:		
Address:		Post Code:
Direct contact tel no:		E-mail address:
Name of host PCO (PCT, LMC etc):		
We may contact you from time to time to keep you up to date with products and services that we feel may be of interest to you. If you would like us not to retain your e-mail address for this purpose, please tick here <input type="checkbox"/>		

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<p>This survey will be undertaken postally. We will send, for each clinician: 40 questionnaires, 40 CFEP addressed pre-paid envelopes and a template letter, 40 postage paid envelopes to mail out with the questionnaire.</p> <p>In order to generate statistically reliable data, please return a minimum of 25 responses. We will contact you to arrange for more to be distributed, if we have not received enough questionnaires.</p> <p>Please provide details of participating clinicians.</p>		
A) General Practitioners		
General Practitioner	Name _____	Gender _____ Date of Birth _____
	Year of Registration _____	Email _____
Please select from the options below which best suits their occupation		
<input type="checkbox"/> Partner	<input type="checkbox"/> Salaried doctor	<input type="checkbox"/> OOH doctor <input type="checkbox"/> Locum
<input type="checkbox"/> Prison doctor	<input type="checkbox"/> Military doctor	<input type="checkbox"/> Registrar <input type="checkbox"/> Other _____
	Are you:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
General Practitioner	Name _____	Gender _____ Date of Birth _____
	Year of Registration _____	Email _____
Please select from the options below which best suits their occupation		
<input type="checkbox"/> Partner	<input type="checkbox"/> Salaried doctor	<input type="checkbox"/> OOH doctor <input type="checkbox"/> Locum
<input type="checkbox"/> Prison doctor	<input type="checkbox"/> Military doctor	<input type="checkbox"/> Registrar <input type="checkbox"/> Other _____
	Are you:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
General Practitioner	Name _____	Gender _____ Date of Birth _____
	Year of Registration _____	Email _____
Please select from the options below which best suits their occupation		
<input type="checkbox"/> Partner	<input type="checkbox"/> Salaried doctor	<input type="checkbox"/> OOH doctor <input type="checkbox"/> Locum
<input type="checkbox"/> Prison doctor	<input type="checkbox"/> Military doctor	<input type="checkbox"/> Registrar <input type="checkbox"/> Other _____
	Are you:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time

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General Practitioner Name _____ Gender _____ Date of Birth _____
 Year of Registration _____ Email _____

Please select from the options below which best suits their occupation

Partner Salaried doctor OOH doctor Locum Are Full time
 Prison doctor Military doctor Registrar Other _____ you: Part time

General Practitioner Name _____ Gender _____ Date of Birth _____
 Year of Registration _____ Email _____

Please select from the options below which best suits their occupation

Partner Salaried doctor OOH doctor Locum Are Full time
 Prison doctor Military doctor Registrar Other _____ you: Part time

B) Nursing, Midwifery and Allied Health Professionals

Nurses, Midwifery and Allied Health Professionals Name _____ Gender _____ Date of Birth _____
 Year of Registration _____ Email _____

Please select from the options below which best suits their occupation

Nurse Nurse Practitioner Health Care Assistant Midwife Are Full time
 Phlebotomist Other _____ you: Part time

Nurses, Midwifery and Allied Health Professionals Name _____ Gender _____ Date of Birth _____
 Year of Registration _____ Email _____

Please select from the options below which best suits their occupation

Nurse Nurse Practitioner Health Care Assistant Midwife Are Full time
 Phlebotomist Other _____ you: Part time

Nurses, Midwifery and Allied Health Professionals Name _____ Gender _____ Date of Birth _____
 Year of Registration _____ Email _____

Please select from the options below which best suits their occupation

Nurse Nurse Practitioner Health Care Assistant Midwife Are Full time
 Phlebotomist Other _____ you: Part time

If you require additional practitioners to be surveyed, please print extra copies of this page.

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Price Guide

Price Guide - An all-inclusive cost of £84 +VAT per participating clinician

Price includes:

- complete survey pack
- feedback report
- supporting materials

Each participating clinician will receive an electronic copy of their report.
 A bound copy is available for £15 + VAT, please tick box

I confirm that I have read and accept the terms and conditions of the service provided by CFEP UK Surveys (see www.cfepsurveys.co.uk or contact us for a printed version).

Signed _____ Date _____

Price calculator

Survey price

Optional extras

Bound report add £15 per clinician

Subtotal

Please add VAT

Total

Please tick here if you would like a VAT receipt

- 1. Complete this form, post / fax it to us and call our Accounts Department on 01392 286926 with your credit or debit card details.**
- 2. Complete this form and post to us with payment.**
 (cheques should be made payable to 'CFEP UK Surveys')

Our address:
CFEP UK Surveys
PO Box 51
Exeter EX4 4WT