

Your Name.....

Date of Birth.....

What is your ethnic group?

We ask all patients for this information. Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group.

A : White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background (please write in)	9i0 9i1 9i2
B : Mixed <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed background (please write in)	9i3 9i4 9i5 9i6
C : Asian or Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background (please write in)	9i7 9i8 9i9 9iA
D : Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background (please write in)	9iB 9iC 9iD
E : Chinese or other ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other (please write in)	9iE 9iF

What is your main spoken language?

We ask all patients for this information. Please tick the appropriate box to indicate your main spoken language.

<input type="checkbox"/> Bengali <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Gujarati <input type="checkbox"/> Hindi <input type="checkbox"/> Japanese <input type="checkbox"/> Mandarin <input type="checkbox"/> Polish <input type="checkbox"/> Punjabi <input type="checkbox"/> Serbian/Croatian <input type="checkbox"/> Thai <input type="checkbox"/> Urdu <input type="checkbox"/> Any other (please write in)	13I1 13I4 13I5 13IR 13I6 13I8 13IW 13IB 13IC 13IE 13It/T 13Ix 13IL 13I..
Not stated <input type="checkbox"/> I do not wish my ethnicity to be recorded <input type="checkbox"/> I do not wish my main spoken language to be recorded	9SD 13ZG