

Validation letter

IMPORTANT INFORMATION ABOUT YOUR OUTPATIENT APPOINTMENT

Dear

You are currently on an outpatient waiting list to be seen by the [INSERT CLINICAL SPECIALTY] service in XX University Health Board. We are sorry that because of COVID-19 you have been waiting longer than usual to be seen.

We know that because of the length of your wait your circumstances may have changed. We are contacting everyone waiting for an outpatient appointment to make sure our waiting lists are accurate and people still need to be seen. It is really important that you reply to this letter so your current needs can be assessed.

Please complete the slip below and the enclosed questionnaire and return them in the prepaid envelope provided. Alternatively, if you prefer, you can complete the questionnaire online at [INSERT WEB ADDRESS]. We need to have your response by [INSERT DATE – MINIMUM OF 4 WEEKS]. If we do not hear from you by this time we will confirm with you that you no longer wish to be reviewed. When we have reviewed your questionnaire we will contact you to discuss what happens next.

The way in which we will be delivering outpatients services is changing. Depending on your personal needs, instead of visiting the hospital you may be offered a telephone or video appointment with your clinician. We will discuss this with you and identify the type of appointment that best suits your needs and explain how this will be done.

If you are offered a face to face appointment we will ensure that you are seen in a safe clinical setting. More information can be found on our website.

If your condition has rapidly or significantly deteriorated, then you should contact your General Practitioner who will give you further advice.

If you have any queries, or if you would like to receive this letter and questionnaire in a different language or format, please contact XXXXXX. [INSERT TIMES AVAILABLE].

REPLY SLIP: PLEASE RETURN WITH YOUR QUESTIONNAIRE

Patient details

My name and address are correct – **Yes / No**

If '**No**', please enter correct address including the postcode:

Please provide a preferred telephone number on which we can contact you and tick a preferred time of day. By providing these details you are giving us consent to contact you using these contacts.

Contact details		Tick preferred method of contact
Home		
Mobile		
email		

What is your language preference? (Please delete as appropriate)

Welsh / English / Other

(If 'Other' please state) _____

Please let us know the time of day you would prefer to be contacted.

Morning

Afternoon

Evening

Any

Patient questionnaire

Patient details

1. Do you still require your outpatient appointment?

Yes / No

If 'NO' please answer QUESTION 2.

If 'YES' please go to QUESTION 3.

2. You have answered 'NO' to question 1. We would like to know the reason/s why you no longer want an outpatient appointment. Please tick all that apply:

- My symptoms have resolved or I am feeling better
- I have been treated by my GP / I visited my GP who has prescribed medication or treatment
- I have been treated by another professional or service in the community
- I have received treatment following an emergency admission to hospital
- I have been treated privately
- Other (please specify) _____

If you have answered 'NO':

- You will be placed on a list for six months. If during this time your symptoms recur, you can contact the hospital for a review of your condition. You DO NOT need to be referred again by your GP.
- Please note that this ONLY applies to the condition/reason you were originally referred for. For all other conditions, please contact your GP.

3. You have answered 'YES'. You will be contacted shortly to discuss your condition. In order to understand a little more about how your condition affects you, please complete the following – tick ALL that apply to you:

- I have had to visit my GP at least once regarding my condition since I was referred
- I think my condition is worse now than when I was referred to a specialist
- My condition affects the way I carry out everyday tasks
- My ability to carry out everyday tasks has worsened
- My condition is affecting my mental health and well-being
- My condition is affecting my ability to work or care for a dependent
- I do not have any support to carry out everyday tasks
- Other (please specify) _____

