

(If you need any help completing this form, please ask at Reception)

NEW PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Welcome to our practice. We are a group practice based at two sites. They are: Mile Lane surgery and Redbank surgery. We trust that your time registered with us will be a happy and healthy one. . Your medical records can take up to 6 months to be transferred to the practice. Filling this form helps us help you. To join the practice and complete your registration processes please follow the steps below. Please note you will not be registered at either Redbank or Mile Lane until you return your completed documents to the practice. **You will also need to produce TWO forms of identification – one photographic (e.g: passport, driving licence) & one proof of address (e.g: utility bill, tenancy agreement etc) in order to set online access to your medical record.**

Step 1	<ul style="list-style-type: none">Complete the GMS1 (purple) form to register your details with the practice. Overseas residents also need to complete the back of this form
Step 2	<ul style="list-style-type: none">Complete the New Patient Questionnaire
Step 3	<ul style="list-style-type: none">Read the information about the Summary Care Record (SCR). The NHS in England has introduced the Summary Care Record, which will be used in emergency care. The record will contain information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you enough information to treat you safely. Additional information can be found: http://www.nhs.uk/summary/ if you wish to opt out of this scheme you MUST complete the Summary Care Record Opt – Out form and return it to the practice with your other completed forms. If you don't complete a form you will have an implied summary care record.
Step 4	<ul style="list-style-type: none">You have the right to choose whether your confidential patient information is used for research and planning. To register or to find out more visit: http://www.nhs.uk/your-nhs-data-matters/ or visit the practice website.
Step 5	<ul style="list-style-type: none">Read the enclosed "Your health record and sharing of information" form and complete stating your choice.
Step 6	<ul style="list-style-type: none">Via My GP APP and patient services we offer 24/7 online access to the practice with the option of booking routine appointments, ordering repeat prescriptions, and other benefits. Complete the practice patient access form to sign up. Further details can also be found on the website https://www.redbankgp.nhs.uk vision on line webpage https://www.myvisiononline.co.uk/vpp/If you have provided an email address your login details will be emailed to you once your registration is completed and accepted by the Health Authority (this can take up to 5 working days). If you haven't provided an email address your online login will be available to collect from our reception desk – allow 5 working days.
Step 7	<ul style="list-style-type: none">Return the registration pack including the GMS1 registration, New Patient Questionnaire and the above forms to our reception desk with TWO forms of identification,

NEW PATIENT HEALTH QUESTIONNAIRE (Age 5 years & over)

Full name		Mr/Mrs/Ms/Miss/Master/Mx/Dr	
Date of Birth		Sex	male/female
Home Phone Number		Ethnic group	
Mobile Number		Language spoken (Do you required an interpreter?)	
Work Phone Number		Height	
Email address		Weight	
Allergies/Intolerances		Employed/ Unemployed/ Occupation	
Have you ever served in the British Armed Services? YES/NO			
Have you moved to England from overseas? YES/NO			
FEMALES ONLY aged 25y to 64y - Date of last cervical smear test?		Result if known?	
Had hysterectomy? YES/NO			

Do you have a disability?	Blind / partially sighted
	Deafness
	Physical disability
	Registered disabled
	Other

If you currently take regular medication please bring a copy of your re-order form from your previous GP or pharmacy

ALL PATIENTS: The practice has adopted the Electronic Prescribing Service please advise your preferred pharmacy (whether you are currently on repeat medications or not)

Nominated Pharmacy

A CARER is someone who provides care on a regular and UNPAID basis for an elderly, ill or disabled relative or friend

Are you a carer? YES / NO

If YES, who do you care for?

What is their relationship to you?

Does somebody care for you? YES/NO

If YES, who cares for you?

What is their relationship to you?

What is their telephone number?

Daytime:

Mobile:

Do you give consent for the practice to discuss any relevant medical information, if appropriate, with the above carer?
YES/NO

Signature of consent:

Date of consent:

Is your carer registered at the practice?

Yes

No

Practice Details:

Which of the following options best describes how you think of yourself?

Woman (including trans woman)	Yes / No	
Man (including trans man)	Yes / No	
Non-binary	Yes / No	
In any other way (please state)	Yes / No	
Is your gender identity the same as the gender you were given at birth?	Yes / No	
<u>Next of Kin:</u> <u>Relationship:</u>	Any other dependents at home, spouse, other:	
Name:	<u>Are they registered at the practice:</u>	
Address:		
Contact No(s):		
	Name	DOB

SMOKING STATUS	Please tick all applicable	Amount smoked	Date stopped smoking
Never smoked			
Smoker			
E-cig user			
Ex-smoker			
Ex e-cig user			

ALCOHOL INTAKE - Please tick the boxes that apply to you and add up the points to find your total					
MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?	Never ↑0 points	Less than monthly ↑1 point	Monthly ↑2 points	Weekly ↑3 points	Daily or almost daily 4 points
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ↑0 points	Less than monthly ↑1 point	Monthly ↑2 points	Weekly ↑3 points	Daily or almost daily ↑4 points
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ↑0 points	Less than monthly ↑1 point	Monthly ↑2 points	Weekly ↑3 points	Daily or almost daily ↑4 points
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No ↑0 points		Yes on one occasion ↑2 points		Yes on more than one occasion ↑4 points
Total for each column					

**If you have scored 3 or more in total please complete the next questionnaire in addition*

QUESTIONS	Scoring System					YOUR SCORE
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the year	
TOTAL SCORE						
SCORING:	0-7 lower risk	8-15 increasing risk	16-19 higher risk	20 or more possible dependence		

If your score is 8 to 19: Advice regarding your alcohol intake can be found on the 'NHS Choices' website <https://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx>, or alternatively, make an appointment with one of our healthcare assistants for a well person check. If your score is 20+: Please make a routine appointment with your GP.

Understanding units and measurements: <https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/>

Have you been diagnosed or suffered from any of the following and date of approx diagnosis:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Chronic Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Palliative | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Motor Neurone Disease |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Osteoarthritis (Hip, Knee, Spine) | <input type="checkbox"/> Learning Disability (.....) |
| <input type="checkbox"/> Rheumatoid Arthritis | | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Mental Health | | |
| <input type="checkbox"/> Chemotherapy (Please state below indication/ Reason) | | |
| <input type="checkbox"/> Radiotherapy (Please state below indication / Reason) | | |
| <input type="checkbox"/> Other (Please state below) | | |
-
-
-

CHILD(S) HEALTH

(For record purposes)

If under 16 years who does child live with?

Mum: Name Contact Number

Dad: Name Contact Number

Both:

Other: Name Contact Number

Please indicate which school your child attends

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<u>Ethnicity:</u>	<u>Nationality:</u>	Asylum Seeker/ Refugee/Homeless
<u>First Language:</u>		<u>Disability:</u> Y/N
<u>Interpreter Required?</u> Y/N		
<u>Support Worker access</u> Y/N		<u>SW details:-</u>

FAMILY HISTORY

Is there any of the following in your family (father, mother, brother, sister) before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member?

Stroke? Yes / No Which family member?

Diabetes? Yes / No Which family member?

Cancer? Yes / No Which family member?

Site of cancer?

Breast Ovarian Bowel Prostrate Lung Other (please state)

IMMUNISATIONS

For all children please remember to bring RED BOOK for appointment.

Travel Vaccinations:

Routine/Occupational:

If you are aged over 65 years - date of:

Flu Vaccination..... Pneumonia VaccinationShingles vaccination

FEMALE PATIENTS

Table with 2 columns and 6 rows: Contraceptive History (complete as appropriate), Date of insertion IUD/Coil, Date of last Depo provera Injection, Date of Implanon/Nexplanon insertion, Date of last pill check, Please give details of any complications in pregnancy.

Please ensure you bring a sample of urine with you to your new patient check

Do you have any information or communication needs that you want us to know about i.e. Large print information, interpreter etc?

Yes / No

If Yes, please provide details below:-

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HOW DID YOU HEAR ABOUT US?

- NHS Choices
Google/Internet
Recommendation
Previous Patients
Other

.....
.....

Thank you for completing this questionnaire and registering with us. Your proposed usual doctor and nursing team will assess the information that you have provided and will invite you for an initial discussion about your health if required. If you would like to discuss anything with your Doctor or Nurse please let us know.



Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

Express consent for medication, allergies and adverse reactions only.

or

Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

Express dissent for Summary Care Record (opt out).

Name of patient:

Date of birth: Patient's postcode:

Surgery name: Surgery location (Town):

NHS number (if known):

Signature: Date:

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below.

Name:

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare
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For more information, please visit <https://www.digital.nhs.uk/summary-care-records/patients>, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6

For office use only:

	Team responsibility	Date requested	Date completed
<ol style="list-style-type: none"> 1. Transfer of care (TOC) record requested and scanned immediately into the patients record 2. Recent medical report requested from previous GP or recent hospital appointment 3. Check if new patient appointment is required 4. If eligible NHS Health check to be booked 5. Blood tests for chronic disease requested / appointment booked or downloaded from the system. See guidance 6. TOC sheet given to admin team for TOC and cervical smears/ vaccination status 	Registration team		
<ol style="list-style-type: none"> 1. Disease register added to care record – with TOC and report received. 2. Past medical -History Significant Medical History / Allergies added to record 3. Vaccination/ Travel/ flu/ Pneumo/ Shingles / vaccination added and invited in if vaccinations required. 4. Children vaccination status – recall-capturing young adults meningitis 14-25 	TOC team		
<ol style="list-style-type: none"> 1. Nursing Home Patient data inputted on the system and given to the Nurse Practitioner team or usual GP to review 	TOC team – ask usual GP to review if needs TCI		
<ol style="list-style-type: none"> 1. Cervical smear history / Mammogram / Bowel screening / AAA screening / Osteoporosis screening / Dexa Scan added and recall dates 	Admin team		
<ol style="list-style-type: none"> 1. All records completed – and signed off by TOC team 	Registration team		

-  **STEP ONE – REGISTRATION TEAM**
-  **STEP TWO – TOC TEAM / ADMIN TEAM**
-  **STEP THREE – SIGNED OFF BY TOC TEAM**

CODING on registration:

Proof of Identity Seen: Passport / Driving Licence/ Other (please state.....)

- (OFFICE USE ONLY) - **#91B to validate patient identity,**
- **#67DJ to inform patient of named accountable GP,**
 - **#9NN60 for patient allocated named accountable GP**
 - **SMOKING (#137.00 please select correct code)**
 - **ALCOHOL (#9k17) (Alcohol Screen – Audit C Completed)**
 - **Has a Carer (#918F.00)**
 - **Carer (#918A.00)**
 - **#6689 – Registered Blind**
 - **#6688 – Registered Partially Blind**
 - **#F59..11 – Deafness**
 - **#IC12 – Hearing Difficulty**
 - **#9NU0 – Interpreter Needed**
 - **#9NUw – Interpreter Needed – British Sign Language**
 - **#13Ji.00 – Military Veteran**
 - **#9182 - Next of Kin**
 - **#13D..11 Homeless**
 - **#13ZN- Asylum seeker**
 - **#13ZB – Refugee**
 - **#13F6100 - Nursing home patient**