Review Date: 03/05/18
Jayne Farrell

New Springwells

Adult New Patient Information Pack

Welcome to the New Springwells Practice

Please find enclosed the following:

1. Registration form (purple)
2. New Patient Health Questionnaire
3. Opt Out Form for the Summary Care Record.
4. Sharing Patient Record Consent Form

To register at the surgery you will need your NHS Number. This can be obtained from your current surgery, your repeat prescription or on any NHS correspondence that you have received. We cannot register you without this number.

Adults over 18 - please complete the above forms and return to the surgery in person with your ID (e.g. passport, driving licence or birth certificate) and a proof of address (e.g utility bill, solicitor's letter, rental agreement).
Under 18's - documentation can be brought in by their parent/guardian (documentation required for under 18's is a birth certificate and red book if possible, this is required to update their vaccination record).

If possible please bring your registration documents into the surgery during our less busy period which is between 2:00pm and 5:00pm.

New Patient Medical

- When all of the above forms are returned to the surgery please book an appointment with reception for your "New Patient Medical", this is required for all patients from 5 years old and above and also applies to under 5 years of age if on medication.
- If you are taking any medication please bring the prescription list from your previous surgery or the boxes of medication themselves along to this appointment.
- We also require a list of your past vaccination history which can be faxed by your previous surgery to us on 01529 240520.

Useful Information

- Visit our website on www.ruralmedical.co.uk
- When you are registered we can provide you with a password for booking online Doctors appointments and ordering medication.
- The text message consent form provided will allow us to send you a reminder text message whenever you book an appointment.
- We ask that you give dispensary 48 hours notice when ordering repeat medication. Their telephone line is open from 10am – 4pm on direct telephone number: 01529 240888.

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title .... Surname / Family name ....

Forename(s) ....

Address ....

Postcode.. Phone No .... Date of birth ....

NHS Number (if known)... Signature ....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name .... Your signature....................................

Relationship to patient .... Date ....

What does it mean if I **DO NOT** have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date..

Ref: 4705

New Springwells

Sharing Patient Record Consent Form

I have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet “Your Electronic Patient Record & the Sharing of Information”.
I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapist, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

SHARE – OUT **(Please tick one of the options below)**

I WOULD ☐ I WOULD NOT ☐

like the information recorded at The New Springwells Practice to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data

SHARE – IN **(Please tick one of the options below)**

I WOULD ☐ I WOULD NOT ☐

like the information recorded at other care teams who are involved in my care to be seen by members of the team at The New Springwells Practice, where I have granted those core teams the right to add to my shared data.

Patient Name	
Date of Birth	
Signature	
Date	

OR

Patient Name	
Patient Date of Birth	
Patient Representative Name	
Relationship to Patient	
Signature	
Date	

New Patient Health Questionnaire for Adults

Your Contact Details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐

Other ……………….

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Number of people Living in the Household ……..

Occupation ………………………………………….

Home Address ……………………………………..

…………………………………………………………

…………………………………………………………

…………………………………………………………

Email: ………………………………………….

Surname* ……………………………………………..

First Name* …………………………………………...

Middle Names ………………………………………..

Known As ………………………............................

Previous Surnames ………………………………

Date of Birth*: ……………………………………

Home Tel*...

Work Tel …………………………………………….

Mobile* ....

Information About You

What is your height* ……………………………..

What is our weight* …………………………....

What is your first language* ……………………

Do you need an interpreter* Yes ☐ No ☐

Ethnic Group*

White - ◯ British ◯ Irish Other (*if other please specify*) ……………...

Black - ◯ Caribbean ◯ African Other (*if other please specify*) ……………..

Asian - ◯ Indian ◯ Pakistani ◯ Chinese Other (*if other please specify)* ……………..

Mixed - ◯ White +Black Caribbean Other (*if other please specify)* ……………..

◯ White + Black African

◯ White + Asian

Previous GP

Name of Previous GP* …………………………………..

Address of Previous GP* ………………………………………………………………………….

……………………………………………………………………… Postcode ………………………...

Proof of Identity and Address Provided

◯ Birth Certificate ◯ Driving Licence ◯ Passport ◯ Utility Bill

◯ Allowance Book ◯ Solicitor's Letter ◯ Offer of Tenancy

◯ Other (*If other please specify)* ………………..

Medical Information

Please list any serious illnesses / operation/ accidents/ disabilities (and for women any pregnancy related problems) and the year they took place

Have you ever suffered from? *(Tick as appropriate)*

Epilepsy	○Yes	○No	Blindness / Glaucoma	○Yes	○No
High Blood Pressure	○Yes	○No	Diabetes	○Yes	○No
Heart Attack / Stroke	○Yes	○No	Depression	○Yes	○No
Cancer	○Yes	○No	Asthma	○Yes	○No
Eczema / Hay Fever	○Yes	○No	COPD	○Yes	○No

If yes, please state the year(s) when you were first diagnosed: ……………………………………...

……...

Please list any medicines being taken and the amount: ………………………………………………

……...

Are you registered disabled? *(If yes, please give details)* ○ Yes ○ No

……...

Are you allergic to any medicines and if so, which? ○Yes ○No

……...

Have you ever refused treatment / screening of any kind if so, what and when? ○Yes ○No

……....

Have you ever suffered from? *(Tick as appropriate)*

Anxiety	○Yes	○No	Depression	○Yes	○No
OCD	○Yes	○No	Bipolar Disorder	○Yes	○No

If yes to any of these, please state the year(s) when you were first diagnosed?

……...

Do you have any other mental health issues? *(If yes please give details)* ………………………………..

……...

Are you receiving or have you received any treatment or therapy? *(If yes please give details of your care and when you received it)* …………………………………………………………………………...

……...

Will

Do you hold a Living Will? ○Yes ○No

(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)

Women

Have you ever had a cervical smear? *(If 'yes', please state when, where And the result)* ○ Yes ○ No ……………………………………………………………………………………………

………

Smoking

Do you smoke? ○Yes ○No

If 'No', have you ever smoked? ○Yes ○No

If you currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?............

Would you like advice on giving up smoking? ○Yes ○No

Alcohol

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirts

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
○ Less than Monthly
○ Monthly
○ Weekly
○ 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

How often during the last year have you failed to do what normally Normally expected of you because of drink

○ Never
○ Less than Monthly
○ Monthly
○ Weekly
○ Daily

In the last year has a relative or friend, or a doctor or a health worker been concerned about your drinking or suggested you cut down

○Never
○Yes, on one occasion
○Yes, more than once

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer:

………..

………..

Carers

Do you have a carer? *(If yes please give details)* ◯Yes ◯No

……..

Are you a carer? (If yes please give details) ◯Yes ◯No

If YES are you an unpaid carer ◯Yes ◯No

……..

Next of Kin

Name of Next of Kin …………………………………………………………………………………………

Relationship to you ……………………………………………………………………………………………

Address ……

………………………………………………………………….. Postcode …………………………………………

Home Tel ……………………………………………………. Mobile ………………………………………………

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? ◯Yes ◯No *(if yes enter date)* ………………………………….

Have you had a pneumococcal vaccination? ◯Yes ◯No

Contacting You

I agree that I may be contacted from time to time with practice news, advice about my health and / or appointment reminders via.

Email: Yes ◯ No ◯
SMS Text Messaging: Yes ◯ No ◯

Online Access

Would you like to register for online access? Online Access allows you to Book or Cancel appointments and order repeat prescriptions online 24 hours a day.

Yes ◯ No ◯

Signature

Signature ………………………………………………………………. Date: ……………………………………..

For Office Use

Checked by: ……………………………………………………………………… Date: ……………………………………………………...

Type of ID photocopied: ………………………………………………… Proof of Address photocopied: ………………………………………..

Appointment Booked: ……...

Actions to take while registering the patient

Read code: *Patient Allocated Named GP* ☐ *Patient Registered GMS1* ☐ *Informing patient of named GP* ☐
If patient lives in a Care Home ☐ *Consent given for electronic record sharing* ☐ *Donor* ☐ *Text Messaging Consented To* ☐
Text Messaging Declined ☐ *Email Consent Given* ☐ *Email Consent Declined* ☐ *Online Access Consented To* ☐
Online Access Declined ☐ *Next of Kin* ☐ *Parental Responsibility* ☐

Other Actions: *Text Messaging, Tick Put in Box* ☐ *Online Access* ☐ *Next of Kin to Family Relationships* ☐
Please pass to Jayne if patient is a carer ☐ *or is cared for* ☐ *If patient is over 75 send over 75 letter* ☐
if the patient has signed the donor section please put Lloyd George in the donor envelope ☐
If the patient is under 5 years of age photocopy GMS1 form and put in the under 5's envelope ☐