Welcome to The New Surgery

For Receptionist use only

A. **New Patient checklist before registrations can be accepted**

- Please check NHS number, DOB, Address (both past and present)
- Previous surname if the patient has the title of MRS
- Date of Entry to UK if coming from abroad
- Telephone contact numbers
- Place of birth (TOWN not hospital)
- Has the patient signed the Purple GMS1 form? ☐
- Has the patient signed the donor section? (if they have ticked any part of this section) ☐

B. ID checked – if available ☐

C. Nominate a pharmacy (page 6) ☐

D. Opt out of the Summary Care Record scheme - please add (page 10) ☐

E. Alcohol screening form – please add (page 7) ☐

F. Has the patient been informed of their accountable GP? Y ☐ N ☐ **GP Name:** ....

HAVE ALL SECTIONS A – F HAVE BEEN COMPLETED?

Form completed by (please print name)……………………………………….

ONCE THIS FORM HAS BEEN CHECKED PLEASE LEAVE IN THE REGISTRATION PIGEONHOLE

THANK YOU

The New Surgery

8 Shenfield Road, Brentwood, Essex, CM15 8AB
Tel: 01277 218393
www.thenewsurgery-brentwood.co.uk

1.) BACKGROUND DETAILS

CONTACT DETAILS

First name	
Surname	Male or Female:
Former surname	
Address	Post code:
Date of birth	
Mobile number	Text message consent: Y N
Home contact number	Home answerphone message consent: Y N
Email address	Email contact consent: Y N
Family registered here?	Y N
Next of Kin	Name: Telephone: Relationship to you:

*** It is your responsibility to keep us updated with any changes to your contact details**

ETHNIC GROUP (please tick):

White British	☐	Black British	☐	Asian British	☐	Pakistani	☐
White Irish	☐	Black Caribbean	☐	Bangladeshi	☐	Chinese	☐
White other	☐	Black African	☐	Indian	☐	Other	☐ *Please state*

Please state ………………………………………………….

EMPLOYMENT

Employed	☐	Student	☐	House husband	☐	Carer	☐
Self-employed	☐	Unemployed	☐	House wife	☐	Retired	☐

Occupation (if applicable):…………………………………………………………………………………..

OVERSEAS VISITORS

Overseas Visitor?	Yes ☐ European Health Insurance Card (EHIC) held (please bring details with you) ☐

COMMUNICATION NEEDS

Language	What is your main spoken language? ....
	Do you need an interpreter? Yes ☐ No ☐
Communication	Do you have any communication needs? (If **YES** please specify below) Yes ☐ No ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog ☐

CARER DETAILS

Are **YOU** a carer?	Yes – informal/unpaid carer ☐ Yes – occupational/paid carer ☐			
Do you **HAVE** a carer?	Yes ☐	Name*:	Tel:	Relationship:

*Only add a carer's details if they give their consent to have these details stored on your medical record

2.) MEDICAL HISTORY

ILLNESSES – do you suffer from (please tick box)

Diabetes (please state type I or II)	☐	Epilepsy	☐	Asthma	☐	COPD	☐	Hypertension	☐

Other (please state): ____

Do you have or have you had (please tick box):

Stroke	☐	Glaucoma	☐	Tuberculosis	☐	Any other long term illness:	

Cancer	☐	Please specify:	Heart problems:	☐	Please specify:

FAMILY HISTORY

Please tick any significant family history of close relatives with medical problems **and confirm which relative e.g. mother, father, brother, sister, grandparent**

Medical condition		Relative	
Asthma	☐		
COPD	☐		
Epilepsy	☐		
Thyroid	☐	Under/overactive (please circle)	
Diabetes/type	☐	Type I ☐ Type II ☐	
Liver disease	☐		
Heart disease	☐		
Stroke	☐		
High BP	☐		
Cancer	☐	(Please also state type)	
Kidney disease	☐		
Depression	☐		

Other ☐ (please state below)

....
....
....
....
....

ALLERGIES (please specify):

Please record any allergies or sensitivities below:	Symptoms:

CHRONIC DISEASE MANAGEMENT Please indicate below your preferred method of communication for chronic disease management:

Letter ☐ [XaR7B]

SMS ☐ [XaQmO]

PRESCRIPTIONS Please name the pharmacy you would like to collect your prescriptions from:
Pharmacy:

CURRENT/REPEAT MEDICATION – Please provide a copy of your repeat prescription from your previous GP if possible. Please state below including dose and frequency if known:

3.) LIFESTYLE

Alcohol: Please answer the following questions which are validated as screening tools for alcohol use.

AUDIT–C 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	
A score of **less than 5** indicates *lower risk drinking*.					TOTAL:	

Scores of 5 or more requires the following 7 questions to be completed:

AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	Scoring System					Your Score
	0	1	2	3	4	
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 last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in last year		Yes, during last year	
					TOTAL:	

3.) LIFESTYLE (CONTINUED)

Height (cm) :		Weight (kg):	

EXERCISE HABIT:

None	☐	Light	☐	Moderate	☐	Heavy	☐	Regular	☐	Please specify:	

SMOKING	
Do you smoke?	Never smoked ☐ Ex-smoker ☐ Yes ☐
How many cigarettes did/do you smoke each day?	Less than one ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+ ☐
Do you use an e-cigarette?	No ☐ Ex-user ☐ Yes ☐
Would you like help to quit smoking?	Yes ☐ No ☐ For further information, please see: www.nhs.uk/smokefree, or call Essex Lifestyle Service: 0300 303 9988

THE PRACTICE OFFERS A QUIT SMOKING PROGRAMME – PLEASE ASK IN THE TREATMENT ROOM FOR DETAILS TO MAKE AN APPOINTMENT

Students Only:
Students are at risk of certain infections, including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see www.nhs.uk/livewell/studenthealth

WOMEN ONLY:

Do you use any contraception? Yes ☐ **No** ☐

If yes, please tick: Barrier (condoms) ☐ Oral contraceptive pill ☐ Implant ☐ Coil ☐ Injection ☐

If needed, please book appointment

Are you currently pregnant? YES ☐ NO ☐ Unsure ☐

Date of last cervical smear: ________________

Have you ever had an abnormal smear result? YES ☐ NO ☐ Details: __________ Date: __________

Number of pregnancies (please include any miscarriages or terminations) ________________

Organ and Blood Donation
NHS Organ Donor Register To register your details on the NHS Organ Donor Register please go to: www.organdonation.nhs.uk NHS Blood Donor Register To register your details on the NHS Blood Donor Register please go to: www.blood.co.uk

BP READING:

Please use the self-checking machine in the treatment room and hand slip to the reception staff with this form or when you next attend the surgery

NEW PATIENT CHECKLIST (FOR PATIENTS TO COMPLETE):

Please tick all the boxes below to confirm you have completed and understood the requirements for new patients so that your registration can be completed successfully:

☐	Completed and signed New Patient Questionnaire
☐	Completed and signed GMS1 form
☐	Photo proof of ID *(e.g. passport, photo driving license or photo ID card)*
☐	Proof of address *(e.g. bank statement, utility bill or council tax from within the last three months)*
☐	If you are on repeat medication please ensure you have at least 30 days of medication from your current surgery and ensure you make an appointment with a GP before you put in a new prescription request with us (please tick to confirm you understand this even if you do not have any repeat medication)

SIGNATURES			
I confirm that the information I have provided is true to the best of my knowledge.			
Signature		Signed on behalf of patient	☐
Print name			
Date			

4.) SHARING YOUR HEALTH RECORD AND ONLINE ACCESS

Please read information **overleaf** before completing this form.

Name	
Date of birth	

YOUR HEALTH RECORD

Do you consent to your GP practice sharing your health record with other organisations who care for you?
Yes ☐ *(recommended option)* No ☐ *(not recommended, please discuss this with your GP before ticking this option)*
Do you consent to your GP practice viewing your health record from other organisations that care for you?
Yes ☐ (recommended option) No ☐

All new patients will be given access to the following services:

1. Booking Appointments ☑
2. Requesting repeat prescriptions ☑
3. Access to my <u>coded</u>* medical records ☑

*Contains any medical codes that have been recorded)

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I have read and understood the information on the leaflet attached to this form ☐
2. I will be responsible for the security of the information that I see or download ☐
3. If I choose to share my information with anyone else, this is at my own risk ☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement ☐
5. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible ☐

If you are registering children under 12 please tick that you would like to have access to their record at the same time as your own ☐

Print name:			
Signature:		Date:	

For practice use only : Coded: Xabui / Registered for online access. XaeEr / Declined online access.

Identity verified through (tick all that apply)	Vouching ☐ Photo ID ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date

ONLINE ACCESS

Online access gives you the ability to view your medical record and test results, as well as order prescriptions and book appointments.

If you would like to apply for this now, please read the information overleaf and then sign the attached application form.

Important Information – please read before signing attached form

If you wish, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medication you take regularly and look at your medical record. You can still use the telephone to call in to the surgery to book appointments as well. It's your choice.

It will be your responsibility to keep your login details safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep it secure. If you are at all worried about keeping printed records safe, we recommend that you do not make copies at all.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details:

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information

For more information about keeping your healthcare record safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society: Keeping Your Online Health and Social Care Records Safe and Secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf