

## Patient's details

Please complete in **BLOCK CAPITALS** and tick  as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female	Town and country of birth
Home address	
Postcode	Telephone number

### Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous doctor while at that address
	Address of previous doctor

### If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving	Date you first came to live in UK
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### If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number	Enlistment date
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### If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

### If you need your doctor to dispense medicines and appliances\*

*\*Not all doctors are authorised to dispense medicines*

- I live more than 1 mile in a straight line from the nearest chemist
- I would have serious difficulty in getting them from a chemist

Signature of Patient     
  Signature on behalf of patient     
 Date

### NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

Signature confirming consent to organ donation

Date

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

### NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register

Date

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: .....

## To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services  
 For the provision of contraceptive services  
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.  
 Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date

Practice Stamp

# **ELMWOOD HEALTH CENTRE - NEW PATIENT QUESTIONNAIRE**

Thank you for wanting to register at Elmwood Health Centre. We aim to give you the best care possible. Please help us to help you by completing this form. The information you give us will be completely confidential and will help us while we wait for your records to come from your previous GP. Please ask for help if you have any problems completing this form. You will be asked to complete the Family Doctor Services Registration form (GMS1) in addition to this questionnaire.

**Date:** .....

Have you been registered with our practice before **YES / NO**

**SURNAME:** .....

**FORENAME(S):** .....

**TITLE:** ..... **DOB:** .....

**ADDRESS:** .....

..... **POSTCODE**.....

**SEX:** MALE / FEMALE      **NHS Number (if known)** .....

**TELEPHONE NUMBER (S):**    **Home**      .....

(Please indicate the preferred number to contact as well)

**Mobile**      .....

**Work**      .....

- We also offer texting service for certain services, please complete the consent form for same provided with the form if you wish /do not wish to avail the service. Currently we can only provide this service for adults who are able to sign the consent form themselves.

**OCCUPATION:** ..... **MARITAL STATUS:** .....

The NHS is required to collect details about your ethnicity. This information is used for monitoring purposes only.

**ETHNIC ORIGIN: (Please tick or write in Other)**

**White British (9S10)**.....    **White Other (9S12)** .....    **Black British (9S41)** .....

**Black Other (9S48)**.....    **Asian British (9iA8)** .....    **Asian Other (9SH..)** .....

**Other (9SJ.. )** ..... **I do not wish to disclose my ethnicity** .....

**Preferred / Main Spoken Language** .....

**Place of Birth** .....

**HEALTH PROFILE**

Alcohol intake in a week (average)		..... Units /Week	
Weight		Height	
Do you smoke Cigarettes/pipe/cigars/roll ups?	Never Smoked	Ex-Smoker (Date stopped smoking)	Smoker (Average number smoked/day)

**Information for Smokers:** We strongly advise that you stop smoking. We offer counseling and treatment to help you stop. Please make an appointment in the Smoking Cessation Clinic for help if you wish to stop smoking.

Are you a Carer? A carer is someone who looks after a relative, friend or neighbour who could not manage without their help	No	Yes
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**MEDICAL HISTORY (Please fill in all the information)**

Do you have any of these problems / had in the past	No	Yes
High Blood Pressure		
Heart Disease		
Stroke or mini stroke		
Diabetes		
Asthma or COPD		
Epilepsy		
Thyroid Disease		
Mental Health Problems		
Cancer		
Any other serious illness (Please specify below)		

## MEDICATION (INCLUDING CONTRACEPTION)

Are you taking any regular medications? (Tablets /capsules, inhalers, etc.)	No	Yes
-----------------------------------------------------------------------------	----	-----

If you are then please provide details of the regular medication or provide a copy of you last prescription printout from your previous doctor

1	
2	
3	
4	
5	

Are you allergic to any medication?	No	Yes
If yes then please provide details		

## VACCINATIONS (Please provide dates if known)

Tetanus		Hepatitis A	
Polio		Hepatitis B	
Pertussis		Typhoid	
Diphtheria		H Influenzae B	
MMR		Rubella	
BCG		Meningitis C	
Yellow Fever			

### **What to do next :**

If you have answered YES to any of the above questions – please check with a receptionist to see if you need an appointment with the doctor. We will not be able to provide you with any medication without first seeing a doctor. All new patients are welcome to make an appointment within six months of registration.

**PLEASE BRING ALL YOUR MEDICATIONS with you when you come for your first appointment.**

**Consent form for getting communications via SMS (Text) messaging**

Please read the following terms and conditions and if you agree to them, provide your mobile phone number in the space provided so we can enable the service for you. If you don't wish to use the service then you can choose that option.

- The service is free of charge
- It is your responsibility to maintain the safety of your mobile to avoid anyone else being able to access SMS (Text) sent to you
- You agree to provide us with your mobile number to receive SMS messages, which could include important communications and results of tests and or reminders from the practice
- If you change your number, lose your mobile phone or no longer wish to use this facility, it is your responsibility to inform us as soon as possible.

Please tick the appropriate option:

- I have understood the above and agree to receive communications from the practice via SMS (Text) messaging
- I do not wish to receive any SMS (Text) messages

Full Name:

Date of Birth:

Address:

Mobile Telephone number:

Signature .....

Date: .....

## **Summary Care Records**

Summary Care Records are being introduced nationally by NHS to improve the safety and quality of patient care.

The Summary Care Record is an electronic record which will give all healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when your GP practice is closed.

Healthcare staff will ask your permission when they need to look at your Summary Care Record. If they cannot ask you, for example if you are unconscious, they may look at your record without asking you. If they have to do this, they will make a note on your record.

### **About your Summary Care Record**

If you decide to have a Summary Care Record it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed.

You may want to add other details about your care to your Summary Care Record. This will only happen if you ask for the information to be included. You should discuss your wishes with the healthcare staff treating you.

### **How will I benefit from having a Summary Care Record?**

Healthcare staff will have quicker access to information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had.

This means they can provide you with safer care during an emergency, when your GP practice is closed, or when you are away from home in another part of England.

You will be able to look at your Summary Care Record at any time at a secure website called HealthSpace. You must register to use HealthSpace to keep it as secure as possible. You can find more information about HealthSpace at [www.healthspace.nhs.uk](http://www.healthspace.nhs.uk) or from your local NHS.

### **Children and the Summary Care Record**

Children will automatically have a Summary Care Record made for them.

If you do not want your child to have a Summary Care Record you will need to fill in an opt out form on behalf of your child and return it to your child's GP practice.

In some circumstances your GP may feel it is in your child's best interests to have a Summary Care Record. For example, if your child has a serious allergy that healthcare staff treating your child should know about.

**IF YOU DO NOT COMPLETE THE ATTACHED OPT OUT FORM THEN NHS AUTOMATICALLY CREATES A SUMMARY CARE RECORD FOR YOU.**



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 (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

#### 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 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