Dr D Handley Dr T Critchfield Dr M Houska Dr B Crosbie
Dr S Pegge Dr R Ponnusami Dr J Mayhew

Angmering Medical Centre
Station Road
Angmering
West Sussex
BN16 4HL

Tel: 01903-786758
Fax: 01903-779823

The Coppice
Herne Lane
Rustington
West Sussex
BN16 3BE

Tel: 01903 783178
Fax: 01903 859027

date as postmark
our ref: BT/csg

Dear Patient

NAMED GP

Welcome to our surgery.

You may be aware that from April all practices are required to provide all patients with a named GP who will have overall responsibility for their care.

Your named GP is Dr _____. Your named GP will have overall supervision for the care and support that our surgery provides to you. This does not prevent you from seeing any of the other GPs in the practice.

You do not need to take any further action, but if you have any questions, or wish to discuss this further with us, please contact the surgery you are registered with (number at the top of this letter).

Thank you.

Yours faithfully

THE COPPICE SURGERY & ANGMERING MEDICAL CENTRE

THE COPPICE SURGERY/ANGMERING MEDICAL CENTRE
NEW PATIENT QUESTIONNAIRE – ADULT

Please complete ALL the relevant questions. The information will help the practice to provide better medical care for you.

Name……. Date of Birth……..

Please tick preferred contact number.

Home no:……... ☐ Mobile No:…….. ☐ E-Mail…...……..…….

Height…… Weight……. Occupation……

Ethnicity……

Place of Birth……..

Next of Kin (Relationship)……. Next of Kin …….

Contact Number (Next of Kin)……

Are you a registered carer? YES/NO
Name of person you care for……..
Do you have a carer?
Name of carer…… Contact number of carer……..

Are you registered blind or partially sighted? YES/NO
Are you registered deaf? YES/NO
Are you registered disabled? YES/NO
Please specify disability. ……..

Do you suffer from any of the following?

		Have you had a review in the last 12 months?
Heart Disease	Y/N	Y/N
Stroke	Y/N	Y/N
High Blood Pressure	Y/N	Y/N
Asthma	Y/N	Y/N
Diabetes:		
Type 1	Y/N	Y/N
Type 2	Y/N	Y/N
Chronic Obstructive Airways Disease	Y/N	Y/N
Epilepsy	Y/N	Y/N
Cancer	Y/N	
If yes please specify type……..…		
Any other serious illness	Y/N	

……..

Family History (Parents, Brothers and Sisters ONLY)

Do you have a family history of any of the following?

1. Heart Attacks Y/N
2. Strokes Y/N
3. Breast Cancer Y/N
4. Ovarian Cancer Y/N
5. Bowel Cancer Y/N
6. Diabetes Y/N

If yes please give details including RELATIONSHIP, ILLNESS and AGE AT DIAGNOSIS.

……
……

Have you had any major operations or serious injuries? Y/N

If YES please give details including diagnosis, year and hospital attended.

……
……

Smoking Status

Do you smoke YES / NO / EX-SMOKER

If so how many – tick relevant box **Less than 10** ☐

10 – 20 ☐

More than 20 ☐

If you would like support and advise to stop smoking - Please contact the Surgery and make an appointment with the Smoking cessation clinic.

If You are an Ex-Smoker what year did you stop? ……

Alcohol Questionnaire

Questions	**Scoring System** 1	2	3	4	5	**Your score**
How often do you have a drink that contains Alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

IF YOU SCORE 5 OR MORE PLEASE COMPLETE THE QUESTIONNAIRE ON PG 3.

Alcohol Users Disorders Identification Test (AUDIT)

Questions	0	1	2	3	4	Your Score
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8 -15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence
*Pint of Regular Beer/Lager/Cider = **2 units***
*Alcopop or Can of Lager = **1.5 units***
*Glass of wine (175 ml) = **2 units***
*Single Measure of Spirits = **1 unit***
*Bottle of wine = **9 units***

Allergies

Do you have any drug allergies? Yes / No
Do you have any other allergies? Yes / No

If YES please list
……
……
……
……

Medication

Are you taking regular medication on a repeat basis?
Please state ……..
……
……
……
……

ADDITIONAL INFORMATION ……
……
……
……
……

Signature …….
Date……..

WE WILL NEED (before registration can take place)

1. **PROOF OF ID (passport, photo driving licence)**
2. **PROOF OF ADDRESS (A formal letter/ statement that has your current address on or address that you will be moving to)**
3. **VALID TELEPHONE NUMBER (also Mobile) for contact.**

ENHANCED DATA SHARING. Please read and complete as necessary.

The Enhanced Data Sharing Model is a new service that allows OOH, Ambulance and Emergency services as well as GPs and Hospital Consultants access to medical record data.

The data made available on the Enhanced Data Sharing Model is limited, it includes allergy information, medication, diagnosis, tests & treatments. It does not include any information relating to sexual health, abuse or complaints.

Patients are able to Opt Out of the Enhanced Data Sharing Model if they wish.
Patient consent will be required by ANYONE accessing their records (unless they are unconscious).
If you would like to OPT OUT of the Enhanced Data Sharing Model then please tick below

I would like to **OPT OUT** of the EDSM	Signed	Date

Summary Care Record (SCR)

The Summary Care Record is a National programme and will enable Healthcare professionals across the country access to the SCR database and patient information.

The SCR will consist of Patient information which will be uploaded from our clinical system on a regular basis. This information will be very limited:

- Medication
- Allergies
- Adverse drug reactions

iPatient consent will be required by ANYONE accessing their records (unless they are unconscious).
If you would like to Opt out of the SCR please tick below

I would like to OPT OUT of the SCR	Signed	Date

General Practice Extraction Service (GPES)/CARE.DATA

Patient information is extracted by GPES in order that the practice can submit data on work performed within the practice. This includes items such as: Childhood vaccinations and the Quality & Outcomes scheme.
The extracted information is then used to pay the practice for the work it has done, and to provide information that forms the basis of our achievement and performance. This is where the data for League Tables will originate from. Such information will be anonymised and therefore patients cannot opt out of this extraction.

However, some patient identifiable information may be extracted for the purposes of improving healthcare and informing commissioning decisions. The type of information that will be extracted may include personal confidential data such as referrals, NHS prescriptions, date of birth, postcode, NHS number and gender.

The GP Practice is just one area that GPES obtain its information from – they also look at information from other health/social care settings, such as hospitals.

You can opt back into your personal information being extracted as above at any time by informing the practice.

If you would like to prevent any patient identifiable information from leaving the practice, or prevent information from being passed from hospital and other healthcare settings, please tick below

I wish to OPT OUT of the GP extraction Patient identifiable data	I wish to OPT OUT of information being passed from hospitals/other providers	Signed	**Date**

LEAVING MESSAGES

In accordance with the Data Protection Act, the Practice needs consent from any patient that has an answer phone and is happy for us to leave a message. If we do not have consent, we will be unable to leave a message on an answer phone or with a 3rd party.

Please complete the appropriate box:

☐ I give consent for the Practice to leave messages on my answerphone
Telephone No……..and/or……..
*complete land line and/or mobile number as appropriate.

☐ I do not give consent for the Practice to leave messages on my answer phone.

☐ I give consent for the practice to send a SMS text message to my mobile phone, as a reminder of pre-booked appointments.
Mobile phone number…….

☐ I do not give consent for the practice to send a SMS text message to my mobile phone.

This consent is to remain in force until further notice of cancellation by me.
Signed…….
Print full name……
Date of birth.__/__/____