Dunster & Porlock Surgeries

NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE (ADULT)
(Revised OCTOBER 2022)

This information will remain strictly confidential. Please make sure you answer all questions and sign the form.

PATIENT DETAILS	**PLEASE COMPLETE IN BLOCK CAPITALS**
TITLE: MR/MRS/MISS/MS/DR/OTHER (please state)	SURNAME:
FORENAMES:	DATE OF BIRTH:

MOBILE TELEPHONE NUMBER:

You will automatically be sent a text reminder for appointments.

Please tick the box if you wish to opt out of this service ☐

EMAIL:

By providing an email address you agree to being contacted by the practice using this method.

Please tick the box if you wish to opt out of this service ☐

Have you ever been registered with the Practice before?

☐ ☐ Yes No **If Yes, why did you leave?**

Allergies: Please give details of any allergies or drug sensitivities you may have.

Specific Needs: Do you have any specific needs that the Practice needs to be aware of e.g. sensory or physical disabilities, phobias, interpreter, religious or cultural requirements? (Please give details)

Patient Online Services Registration Form

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online.

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.

Things to consider

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 to you. 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 for a clearer explanation.

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

Patient Online Services Registration Form

Having read the previous page, I would like to have access to the following GP online services (tick all that apply):

Booking appointments	
Requesting repeat prescriptions	
If repeat prescriptions online access requested and you live more than one mile from a chemist you can collect your medication from our Dunster Surgery and this will be added to your nomination If you live within one mile of a chemist please nominate where you would like to collect your medication from: Tesco, Minehead ☐ Boots, Minehead☐ Alcombe Pharmacy ☐ Porlock Pharmacy ☐ Other ☐ please state…….. This information will be added to your notes and will be the primary chemist for you to collect your medication from.	
Accessing my medical record **(can only be requested if photo ID has been provided)**	
Sign up for SMS messaging and appointment reminders (mobile no, must be provided on the front page of this form)	

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

I have read and understood the information leaflet provided by the practice	
I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
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	

Your login details will be sent to you upon registration.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

Information about you: ***If you do not complete this information and have provided a mobile phone number we will send you a text when we register you to gather this information.***

What is your:	
Height	
Weight	
If you have access to a blood pressure machine please provide an up to date reading:	

What is your current smoking status		
Never Smoked	Ex Smoker	Current Smoker
If current smoker or ex-smoker how many cigarettes or ounces of tobacco do you/did you smoke per day?		
Would you like some help to stop smoking?		Yes/No
If you are an ex-smoker, what year did you cease smoking		

Do any of your family members have the following chronic diseases		
Chronic Disease	**Age at Diagnosis**	**Family member**
Diabetes		
Heart Disease		
Stroke		

Do you drink alcohol? Yes/No

This is one unit of alcohol…


Half pint of "regular" beer, lagelf r or cider


Half a small glass of wine


1 single measure of spirits


1 small glass of sherry


1 single measure of aperitifs

If Yes,

How often do you have an alcoholic drink? (circle your answer)

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? (circle your answer)

1-2	3-4	5-6	7-9	10+

How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? (circle your answer)

Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

CHOICES ABOUT SHARING YOUR INFORMATION

Summary Care Record (SCR):
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 by ticking the appropriate box:

- ☐ **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.

Carers and those with carers

Dunster and Porlock Surgeries keeps a register of patients who either care for an elderly, infirm or disabled relative or friend or those patients who require the help of a relative or friend, to enable us to offer appropriate help and advice. Please tick the appropriate box.

I am the main carer for an elderly, infirm or disabled relative or friend. What help do you give?

I rely on the help of a friend or relative to enable me to continue living at home. What assistance do you receive?

Name of your carer or the person you care for:

Consent to authorise another person to receive medical information on your behalf

If you want us to be able to give information to a relative, friend or carer please complete the form below.

Details of person to be given access to this Patient's information:

Full name	
Address and contact number	
Relationship to you	

(if more than one person is to be given access please list below additional name and contact details:

If the above named is not your next kin please provide your next of kin details below (this information will be solely for Practice use and will not be used to give them access to your medical records).

Full Name	
Address and contact number	
Relationship to you:	

Ethnicity

☐ White British ☐ White Irish ☐ White Other ☐ Black African ☐ Black Caribbean

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other (please state) _____

What is your first language?

☐ English ☐ Other (please state) _____

WILL YOU NEED AN INTERPRETER YES/NO

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

SIGNATURE ……DATE ……..

☐ Signed by Patient ☐ Signed on behalf of Patient

FOR PRACTICE USE ONLY

Registration received by	**Date**
ID Seen (if not, reason)	**Registration data entered by**
Online registration authorised	**Date**

NB: If patient has been registered at practice before check reason for returning has been supplied.

If patient is resident in a nursing home pass to Practice Manager.