**Meir Park And Weston Coyney**

**Today’s Date:**

**Medical Practice**

# New Patient Registration Form

Welcome to our practice. In order for us to provide the best possible treatment for you it is essential that we know as much information about you as possible. Therefore we would be grateful if you could provide us with the following information about yourself and hand this form to the receptionist when registering with us. Thank you.

|  |  |
| --- | --- |
| **Full Name: Mr/Mrs/Miss/Ms/Other……….** | **Telephone Number:** |
| **Do you have an information or communication preference? If so please advise, e.g. large print, braille, via email, support** | **Work Number :** |
| **Current Medication:** | **Mobile Number:****Do you consent to receiving text messages?****Yes No**  |
| **E-mail Address:** **Do you consent to register for online access****Yes  No**  |
| **Medical Problems/Illnesses:** | **Date of Birth :**  |
| **Previous Surname if different:** |
| **Marital Status:** |  | **Gender:** | **Male:** | **Female:** | **Other residents of your home:** |
| **Occupation:** |  |
| **Your****Religion:** | **C of E** | **Catholic** | **Other Christian (state)** | **Buddhist** | **Hindu** | **Muslim** |
| **Sikh** | **Jewish** | **Jehovah’s Witness** | **No religion** | **Other religion (state)** |
| **Your Ethnic Origin:****(select one)** | **White (British)**  | **Mixed British** | **White (Other) (please State)** |
| **Black Caribbean** | **Black African**  | **Asian/British Indian**  | **Other Mixed** **Background**  |
| **Indian /** **Brit Indian**  | **Pakistani /** **Brit Pakistani**  | **Bangladeshi / Brit Bangladeshi**  | **Other Asian (please state)****Background**  |
| **Other Black (please state)****Background** | **Chinese**  | **Other**  | **Ethnic Category** **not stated**  |
| **Your main or 1st language Spoken / Understood** | **English** | **Hindi** | **Gujurati** | **Urdu** | **Bengali /Sytheti** | **Punjabi** |
| **Ukrainian** | **French** | **German** | **Spanish** | **Other:(Please Specify)** |
| **Smoking** |
| **Are you currently a smoker?** | **Yes** | **No** | **Have you ever been a smoker?** | **Yes** | **No** |
| **If so, how many cigarettes / cigars / tobacco do you smoke in a day?** |  | **If you have smoked please state date stopped \_\_\_\_\_\_\_\_\_\_** |

***If you are a smoker and want to stop, do you want to be referred for advice? Yes  No ***

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| **Alcohol (please circle your answer to the following questions)** |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times per month | 2-4 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 |
| **Physical Activity** **(please tell us the type and amount of physical activity involved in your work)** |
|  |  | Mark only **ONE** box |
| a | I am not in employment |  |
| b | I spend most of my time at work sitting |  |
| c | I spend most of my time at work standing or walking |  |
| d | My work involves definite physical effort including handling of heavy objects and use of tools |  |
| e | My work involves vigorous physical activity including handling of very heavy objects |  |
| **During the last week, how many hours did you spend on each of the following activities****Please answer whether you are in employment or not** |
|  |  | Please tick **ONE** box only on **EACH** row |
|  |  | None | Some but less than 1 hour | 1 hour but less than 3 | 3 hours or more |
| a | Physical exercise such as swimming, jogging, aerobics, football, tennis, gym |  |  |  |  |
| b | Cycling including to work and during leisure time |  |  |  |  |
| c | Walking including to work, shopping for pleasure etc |  |  |  |  |
| d | Housework/childcare |  |  |  |  |
| e | Gardening/DIY |  |  |  |  |
|  |  |  |  |  |  |

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| How would you describe your usual walking pace? **Slow Steady average pace**  **Brisk pace Fast pace** |
| **Specific Needs:****Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** |
| **Do you require the help of a Translator / Interpreter?** |  |
| **Please state any allergies and sensitivities you have:** |  |
| **If you are a Carer, please state the name / address / phone number of the person you care for:** | **Person Cared For Contact Details:** |
| **If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.** | **Carer Contact Details:** |
|  **Signed: Date:** |

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| **Medication**If you are on repeat medication please attach a copy of your repeat prescription request slip to this form. If you would like to collect your prescription from a local chemist rather than the surgery please indicate which chemist and we will mark your records accordingly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ You can view and request your repeat prescriptions by logging on to the internet 24 hours a day, 365 days a year. If you would like to order your repeat prescriptions on line please tick the box and we will send you the information and password to get you started. **Yes I would like to order my prescriptions on line**  |

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| **Patient Participation Group****The Practice is committed to improving the services we provide to our patients.** **To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.** **By expressing your interest, you will be helping us to plan ways of involving patients that suit you.** **It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.****If you are interested in getting involved, please tick the box below and we will contact you in due course.** |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group** **(Please tick the “Yes” Box)** | **Yes** |
|  |
| **Patient****Signature:** |  | **Signature on****behalf of Patient:** |  |

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| **Summary Care Records.****The NHS are changing the way your health information is stored and managed.** **The NHS Summary Care record is an electronic record of important information about your health.** **It will be available to health care staff providing your NHS Care. Please see attached letter.** |
| **Are you happy to have a Summary Care Record?** | **Yes** | **If No then complete the attached form** |

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

* ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
* ***Social factors - employment, housing, family circumstances***
* ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

**Thank you for completing this form**

***For more information about the services we offer, please refer to our practice leaflet
 or see our website: www.westoncoyneymedicapractice.nhs.uk***

 

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

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 on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.
3. **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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

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

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out next page).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

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

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

 ***Meir Park And Weston Coyney Medical Practice***

**Sharing Your Medical Record – Opt out form**

|  |  |  |
| --- | --- | --- |
| **Title** | **Surname** | **Forename** |
| **Address (please include postcode)** |
| **D.o.B** | **Telephone number** |  |
| *If you are filling out this form on behalf of another person or child, please ensure you fill out their details above and your details below* |
| **Your Name** | **Relationship to the patient** |  |

**\*\*PLEASE ONLY SIGN THOSE SECTIONS BELOW THAT YOU WISH TO OPT OUT OF\*\***

1. **Shared Medical Records in North Staffordshire & Stoke on Trent (leaflet available in reception)**

Health services in North Staffordshire and Stoke-on-Trent are introducing a new system of sharing medical records. If you attend the Accident and Emergency Department, Acute Medical Unit, Surgical Assessment Unit or the Frail Elderly Assessment Unit at University Hospital of North Staffordshire, the Consultants/Doctors there will be able to view some of your GP medical record - but only with your permission.

I ***DO NOT*** wish to share my medical record for the purpose identified above (93C1) (XaKRw)

|  |  |
| --- | --- |
| **SIGN** | **DATE** |

1. **Summary Care Record (information available on request)**

Data is uploaded from your GP practice to create your Summary Care Record (SCR). Your SCR contains important information about your medication, allergies and reactions to medicines that you have had. This information can then be used when caring for you in an emergency, when your GP practice is closed or when you are away from home elsewhere in England. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. You may want to add other details about your care to your Summary Care Record eventually. Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, e.g. if you are unconscious, healthcare staff may look at your record without asking you. If they have to do this, they must record the reason on your record.

I ***DO NOT*** wish to share my medical record for the purpose identified above (9Ndo) (XaXj6)

|  |  |
| --- | --- |
| **SIGN** | **DATE** |

1. **Better Information means better care (leaflet available in reception)**

GP practices across England are now required to supply information about patients’ and the care they receive, to the Health and Social Care Information Centre (HSCIC). Under the Health and Social Care Act 2012, GP practices have no choice but to allow the HSCIC to extract this information. The NHS uses this information to plan and improve services for patients. Information such as your postcode and NHS number (never your name) will be used to link records in a secure system so that information which does not reveal your identity can be used by others such as researchers and those planning health services to make sure we provide the best possible care for everyone.

I ***DO NOT*** wish to share my medical record for the purpose identified above

 (9Nu0 & 9Nu4)(XaZ89 & XaaVL)

|  |  |
| --- | --- |
| **SIGN** | **DATE** |

**ACCEPTABLE BEHAVIOUR AGREEMENT**

We are committed to promoting access to our services and offering choice wherever possible in the services we provide and the way we deliver them. An acceptable behaviour agreement is an individual written agreement between a patient and their GP practice.

The agreement is between:

|  |  |
| --- | --- |
| PRINT NAME |  |
| DATE OF BIRTH |  |

And Meir Park and Weston Coyney Medical Practice, and is valid from the date shown in the signature table below.

Meir Park and Weston Coyney Medical Practice will ensure you are dealt with quickly, fairly and in a courteous and helpful manner.

Meir Park and Weston Coyney Medical Practice will ensure that staff take responsibility for resolving or dealing with your query or that they refer it to an appropriate colleague.

**The Conditions:**

The above-named person applying for registration at the practice agrees to the following:

1. To refrain from using abusive or offensive language, making threats of violence or aggressive behaviour and to treat all staff fairly and with respect; in person, on the phone, in writing or on social media.
2. To utilise the practice’s Complaints Process to raise concerns about care or service received, rather than posting anonymous feedback on social media.
3. To cancel any appointments they are unable to attend with as much notice as possible.
4. To Meir Park and Weston Coyney Medical Practice’s DNA (Did Not Attend) policy - if they miss three appointments without notifying the surgery, they may be removed from the practice list and will have to register with a different practice.
5. To adhere to Meir Park and Weston Coyney Medical Practice’s repeat prescription policy and agree to allow 3 working days before collecting repeat prescriptions.

**Breach of this Agreement:**

If the above-named person fails to adhere to the above conditions, they may be removed from the practice list. This serves as an initial warning in the event of breaches occurring.

**Declaration:**

**I confirm that I understand the meaning of this agreement and that the consequences of breaking any condition(s).**

|  |  |
| --- | --- |
| Signature |  |
| Date |  |