

Dear Patient

We would like to take this opportunity to thank you for choosing us as your GP and welcome you to our practice.

As part of your registration as a patient with this practice, we ask that you make an appointment to come and meet with your new GP within one month of registering.

The purpose of this visit is to give your GP the opportunity to get to know a little about your medical history as well as any current medical problems you may be experiencing. In addition to this we would also like to review any regular medication which you may be taking at present.

We have a total of 8 GP’s working within the practice and you are welcome to make an appointment with any GP of your choice.

Finally we hope that you will find the services we offer as welcoming and helpful, should you incur any problems whilst registered at the practice, please don’t hesitate to speak to one of our Receptionists or if your concerns are of a more serious nature please ask to speak to our Practice Manager

Thank you

**NEW PATIENT REGISTERING WITH THE PRACTICE**

Please complete all the enclosed and return to reception

If possible please supply your NHS number

In order to help with your registration the practice will ask for proof of your

identity **(ORIGINALS NOT PHOTOCOPIES), including photo ID. ( Registration will not be refused without ID. The Practice is registered with Safe Surgeries/Doctors of the world)**

PLEASE SUPPLY **2** OF THE FOLLOWING. **ONE MUST BE PHOTO ID** and **ONE**

**PROOF OF YOUR CURRENT ADDRESS** dated within the last 3 months (e.g. Utility

Bill/Bank/Building Society Statements)

 Birth Certificate

 Marriage Certificate

 NHS Medical Card

 Driving Licence

 Passport

 National Insurance Number Letter

 Payslip

 P45

 Proof of current address

--ooOoo—

**Online Services: EMIS Web**

You will be able to request repeat prescriptions, book some appointments & much more online. All you need is a username and password.

To obtain your unique username and password please ask at Reception.

**Electronic Prescriptions Service**

If you have repeat medication prescribed you will be asked if you would like the practice to send your prescription electronically direct to the Pharmacy of your choice.

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.  
If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

**Patient Checklist for Completing this Questionnaire**

|  |  |
| --- | --- |
| **Completion Required** | **Please Tick when completed** |
| Purple NHS Form completed |  |
| Supply copy of Prescription Counterfoil |  |
| Next of Kin Details **(pg 2)** |  |
| Internet Access **(pg 5)** |  |
| Electronic Consent Form **(pg 6)** |  |
| Summary Care Record **(pg 8)** |  |
| Read Privacy Notice |  |
| Carers Questionnaire**(pg 9)** |  |

**Please complete a separate form for each family member to be registered.**

**Patient Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mr / Mrs / Miss / Ms / Other……..** | | | | | | | | **Surname** | | | |  | | | | |
| **Date of Birth:** | | |  | | | | | **First Names** | | | |  | | | | |
|  | | |  | | | | | **Previous / Mother’s surname if different** | | | |  | | | | |
| **Email Address** | | |  | | | | | | | | | | | | | |
| **Address** | | |  | | | | | | | | | | | | | |
| **Postcode** | | |  | | | | | **Home Telephone Number** | | | |  | | | | |
| **Mobile Telephone Number** | | |  | | | | | **Work Telephone Number** | | | |  | | | | |
| **Marital Status** | | |  | | | | | **Occupation** | | | |  | | | | |
| **If registering a child of school age, Please tell us the name of the school they attend.** | | | | | | | |  | | | | | | | | |
| |  | | --- | | **Which of the following options best describes how you think of yourself?** | | | | | | | | | | | | | | | | | |
| **Heterosexual** | | **Gay** | | **Lesbian** | | | | | **Bisexual** | | **In another way:** | | | | |
| **Which of the following options best describes how you think of yourself?** | | | | | | | | | | | | | | | | |
| **Man**  **(including trans man)** | | | | | | **Woman**  **(including trans woman)** | | | | **Non-binary** | | | **In another way:** | | | |
| **Is your gender identity the same as the gender you were given at birth?** | | | | | | | | | | | | | | | | |
| **Yes** | | | | | | **No** | | | |  | | | | | | |
| **Your Ethnic Origin:**  **(select one)** | | | | | | | | | | | | | | | | |
| **White (UK)**  **9i0** | **Caribbean**  **9i3** | | | | **African**  **9i4** | | **Asian 9i5** | | | **White (Irish)**  **9i1%** | | | | **White (Other)**  **9i2%** | **Other Mixed**  **Background 9i6%** | |
| **Indian /**  **Brit Indian 9i7** | **Pakistani /**  **Brit Pakistani 9i8** | | | | **Bangladeshi / Brit Bangladeshi 9i9** | | **Other Asian**  **Background 9iA%** | | | **Other Black**  **Background** | | | | **Chinese**  **9iE** | **Other**  **9iF%** | |
| **Ethnic Category**  **not stated 9iG** |  | | | |  | |  | | |  | | | |  |  | |
| **Your main or 1st language Spoken / Understood** | | | | | | |  | | | | | | | | | |

**Next of Kin**

|  |  |
| --- | --- |
| **Next of Kin** |  |
| **Relationship to you** |  |
| **Their Contact Number** |  |

**Armed Forces**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Have you ever served in the armed forces?** |  |  | |  |  |  |
| **If YES are you still a reservist? (Code as Xabnw)** |  |  | |  |  |  |
| **Service or Personnel No:** |  | | | | | |
| **Enlistment Date** |  | | **Leaving Date** | |  | |

**Your Health**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Please tick if you have a history of any of the following** | | | | | | | |
| **Cancer** |  | **Dementia or Alzheimers** |  | **Coronary Heart Disease, Heart Failure or Atrial Fibrillation** |  | **Hypertension (High Blood Pressure)** |  |
| **Depression or Mental Health Problems** |  | **Asthma or COPD** |  | **Stroke or TIA** |  | **Diabetes** |  |
| **Learning Disabilities** |  | **Learning Difficulties** |  | **Epilepsy** |  | **Thyroid Disease** |  |
| **Please list any other history, important illnesses or disabilities not mentioned above. Please also list any operations** | | |  | | | | |
| **Please list any ALLERGIES you may have** | | |  | | | | |
| **Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency** | | |  | | | | |

**Have your parents, brother(s) or sister(s) suffered from any of the problems below – please tick and then circle which family member**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Diabetes** |  | Father | Mother | Sister | Brother |  |
| **Asthma** |  | Father | Mother | Sister | Brother |  |
| **High Blood Pressure** |  | Father | Mother | Sister | Brother |  |
| **Stroke** |  | Father | Mother | Sister | Brother |  |
| **Heart Disease** |  | Father | Mother | Sister | Brother |  |

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|  | | | | | | |
| **When was your last smear test** | **Date** | | **Normal** | | **Abnormal** | |
| **Do you use any form of contraception? If so please indicate which** | Coil | Depot | Implant | Oral Pill | Patches | Other? |
| **If you have a Coil or Implant, approximately what date was this fitted?** | **Date fitted** | | **If you have Depot Injections, please tell us the date of your last one** | | **Date Given** | |
| **If applicable, please tell us the date of your last mammogram** | **Date** | |  |  |  |  |

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| **Smoking** | | | | | | | | | | | |
| **Never Smoked** | | |  | | | | | | | | |
| **Ex-Smoker**  **When did you stop?** | | |  | | | | | | | | |
| **Smoker, how many per day?** | | |  | | | | | | | | |
| ***If you are a smoker and want to stop, please ask for information about local smoking cessation services***  See the source image | | | | | | | | | | | |
| **Alcohol Consumption** | | | | | | | | | | | |
| **How often do you have a drink containing alcohol** | N/A | Never | | | Monthly or less | | 2-4 times per month | | 2-3 times per week | | 4+ times per week |
| **How much alcohol do you drink in a week (Units)?**  *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)* | N/A | 1-2 | | | 3-4 | | 5-6 | | 7-9 | | 10+ |
| **How often in the past year have you found that you were unable to stop drinking once you had started** | N/A | Never | | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |
| **How often in the past year have you failed to do what was expected of you because of alcohol?** | N/A | Never | | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |
| **Has a relative/friend or Healthcare Professional been concerned about your drinking or suggested you cut down?** | N/A | No | | | Yes but not in the past year | | Yes during the past year | | Weekly | | Daily or almost daily |
|  | | | | | | | | | | | |
| **Exercise** | | | | | | | | | | | |
| **Please circle which of these terms best describes how much exercise you take on a regular basis.** | | | | **None** | | **Light** | | **Moderate** | | **Heavy** | |

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| **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:** | | | |
| **Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):** | |  | |
| **Are you an ‘Assistance Dog’ User?** | |  | |
| **Please state any Physical disabilities you have:** | |  | |
| **Please state any Mental disabilities you have:** | |  | |
| **Please state any requirements you have to be able to access the Practice premises** | |  | |
| **Please state any Religious or Cultural needs:** | |  | |
| **Do you require the help of a Translator / Interpreter?** | |  | |
| **Please state any specific nutritional requirements you have:** | |  | |
| **Please state any allergies and sensitivities you have:** | |  | |
| **If you are a Carer or have a carer, please complete the attached carers form at the back of this** | | | |
| **Do you have a “Living Will”**  **(a statement explaining what medical treatment you would not want in the future)?** | Yes | No | ***If “Yes”,can you please bring a written copy of it to your New Patient Consultation*** |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | Yes | No | **If “Yes”, please state their name / address / phone number:** |

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| --- | --- | --- | --- |
| **Named GP for Patients** | | | |
| All of our patients have been allocated a Named GP who is in overall charge of their care.  You can find out who your Named GP is by looking at the right hand side of your prescription or by asking one of our friendly receptionists who can easily look this up for you.  Please be aware that having a Named GP does not prevent you seeing another doctor in the Practice as your named GP will not be available at all times. | | | |
| **Internet Access** | | | |
| **Would you like access to online appointments and repeat prescriptions?**  ONLY AVAILABLE FOR OVER 16 YEARS | | Yes | No |
| **PLEASE NOTE:**  ***For more information about the services we offer, please see our website:***  www. <https://www.cornishwaygp.co.uk/> | | | |
| **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 arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.** | | | |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the Box)** | **No, I am not interested in becoming involved in the Practice Patient Participation Group (Please tick the Box)** | | |
|  |  | | |

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| --- | --- |
| **Signature of Patient** |  |
| **Or signature on behalf of the patient** |  |
| **Date** |  |

**Electronic Communication Consent Form**

I hereby consent to the practice contacting me by text message and/or email for the purposes of appointment reminders, health promotion, test results and practice news on the contact number and/or email address given below.

I understand and confirm the following:

1. The forwarding of appointment reminders by text is an additional service provided by the practice and that reminders may not be sent on all occasions.
2. I remain responsible for attending or cancelling appointments.
3. Although text messages are generated using a secure facility they are transmitted over a public network onto a personal telephone and as such may not be secure.
4. I am responsible for notifying the practice of any change in contact details.
5. I have the right to cancel the text message / email facility at any time.

|  |  |
| --- | --- |
| Patient’s Name: |  |
| Date of Birth: |  |
| Home Tel: |  |
| Mobile No: |  |
| Email address: |  |
| Patient’s Signature:  Date: |  |
| **Where the patient is under the age of 13, consent may be given by a person holding Parental Responsibility. All patients attaining the age of 13 years will be required to provide their signed consent for this service to be continued.** | |
| Name of person holding Parental Responsibility: |  |
| Signature:  Date: |  |

**For Staff Use Only**

|  |  |  |
| --- | --- | --- |
| **Staff,** Please add the following applicable read codes, as per consent given by the patient. Please scan this written consent document to the patients record | | |
| **Consent Codes** | **Consent not given** | **Withdrawal Codes** |
| Consent given for email communication - **9Nds** | Declined consent for email – **9Ndy** | Withdrawn consent for email – **9Nde** (only if the pt’ changes their mind and we receive written consent) |
| Consent given for text message – **9Ndp** | - | Withdraw consent for text message – **9NdQ0**(only if the pt’ changes their mind and we receive written consent) |

**NHS PATIENT INFORMATION SHARING – MY CHOICES**

**Summary Care Record**

The new NHS Summary Care Record has been introduced to help deliver better and safer care and

give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

• any allergies you may have,

• unexpected reactions to medications,

• and any prescriptions you have recently received.

The intention is to help clinicians in A & E Departments and ‘Out of Hours’ health services to give you

safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are

authorised to do so and, even then, only if you give your express permission. You will be asked if

healthcare staff can look at your Summary Care Record every time they need to, unless it is an

emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

**Sharing Your Health Record**

**What is your health record?**

Your health record contains all the clinical information about the care you receive. When you need

medical assistance it is essential that clinicians can securely access your health record. This allows

them to have the necessary information about your medical background to help them identify the

best way to help you. This information may include your medical history, medications and allergies.

**Why is sharing important?**

Health records about you can be held in various places, including your GP practice and any hospital

where you have had treatment. Sharing your health record will ensure you receive the best possible

care and treatment wherever you are and whenever you need it. Below are some examples of how

sharing your health record can benefit you:

• Sharing your contact details This will ensure you receive any medical appointments without delay

• Sharing your medical history This will ensure emergency services accurately assess you if needed

• Sharing your medication list This will ensure that you receive the most appropriate medication

• Sharing your allergies This will prevent you being given something to which you are allergic

• Sharing your test results This will prevent further unnecessary tests being required

**Is my health record secure?**

Yes. There are safeguards in place to make sure only organisations you have authorised to view your

records can do so.

**Can I decide who I share my health record with?**

Yes. You can decide who has access to your health record. For your health record to be shared

between organisations that provide care to you, your consent must be gained.

**Can I change my mind?**

Yes. You can change your mind at any time about sharing your health record, please just let us know.

**Can someone else consent on my behalf?**

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on

your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can

made by those caring for you.

**What about parental responsibility?**

If you have parental responsibility and your child is not able to make an informed decision for

themselves, then you can make a decision about information sharing on behalf of your child. If your

child is competent then this must be their decision.

**What is your Summary Care Record?**

Your Summary Care Record contains basic information including your contact details, NHS number,

medication and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services.

If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out

form. With your consent, additional information can be added to create an Enhanced Summary Care

Record. This could include your care plans which will help ensure that you receive the appropriate

care in the future.

For further information, please see: www.nhs.uk/NHSEnhland/thenhs/records

**Please complete and/or tick grey boxes below to detail your personal decisions regarding the 3 aspects of NHS patient data sharing.**

**It is very important you sign this form to say that you understand and accept the risks to your personal health care. If you decide to opt out of SCR (Summary Care Record) or EDSM (Enahnced Data Sharing Model) “EMIS Web”**

|  |  |
| --- | --- |
| **Patients Full Name** |  |
| **Patients Date of birth** |  |

1. **SCR – NHS SUMMARY CARE RECORD**

Please tick only one box below

**Express consent** for medication, allergies and adverse reactions only (**9Ndm**)

**Express consent** for medication, allergies, adverse reactions and additional information (**9Ndn**)

**Express dissent** – Patient does not want a summary care record and fully understands the risks

involved with this decision (**9Ndo**)

If you choose 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.

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 your relationship with the patient**

|  |  |  |
| --- | --- | --- |
| Parent | Legal Guardian | Lasting power of Attorney for Health & Welfare |

|  |  |
| --- | --- |
| **Signature of Patient** |  |
| **Or signature on behalf of the patient** |  |
| **Date** |  |
| **Please note that by signing this form you are consenting to receiving texts and or emails from the practice** |  |

**Thank you for completing this NHS GP Registration Form**

**It Helps Us to Help You ☺**

|  |  |  |
| --- | --- | --- |
|  |  |  |

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| --- |
| **Carers Questionnaire** |

Who is a care? – A carer is someone, who, without payment provides help and support to a partner, child, relative, friend or neighbour who could not manage without their help. This could be due to being elderly, physically or mentally impaired or addiction

We would be grateful if you could complete the following questions for the practice Carer’s Register. The register enables the practice to proactively manage carer’s needs with the practice and to consider the provision of services to carers. The practice will also ensure that all patients who are carers are informed of and supported in joining the local carer’s link network

**IF YOU ARE A CARER** – Please complete this section

|  |  |
| --- | --- |
| **What is the relationship to the person you care for?** |  |
| **Details of the person(s) you are caring for** | |
| **Title** |  |
| **Surname** |  |
| **Forname** |  |
| **DOB** |  |
| **Address** |  |
| **Telephone Number** |  |
| **Please tick here if you would like a FREE Carers Health and Wellbeing Check and one of our Practice Nurse will contact you to arrange an appointment at the practice.** | |

**IF, YOU ARE BEING CARED FOR?** – Please complete this section

|  |  |
| --- | --- |
| **What is the relationship with your carer?** |  |
| **Details of you Carer** | |
| **Title** |  |
| **Surname** |  |
| **Forname** |  |
| **DOB** |  |
| **Address** |  |
| **Telephone Number** |  |

If you consent to your Carer being informed of medical information about you which is held at the practice, please sign and date below, If **NOT** leave blank

Signed………………………………………. Date ………………………………………

**Informing Patients of Their Named Accountable GP**

**When Registering With The Practice**

**Registration Staff to Complete**

|  |  |  |
| --- | --- | --- |
| Read Code (9NN60) added to patient record – Patient Allocated Named Accountable GP | Staff Signature | Date |
| Read Code (67DJ) added to patient record - Informing Patient of Named Accountable GP |  |  |