willowbrook Medical Practice

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NHS
Providing NHS services

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New Patient Questionnaire Documentation

- Please be aware that it can take **up to 24 - 48 hours before your registration is transferred**. Therefore, you will not be able to make appointments or get prescriptions until this is complete.
- If you need to be seen urgently then you will be registered as immediately necessary until your registration is complete.
- **Can you please ensure to get your NHS number from your previous Doctors and a list of any repeat medication.**

NEW PATIENT: Please read below before completing form and use BLOCK CAPITALS THROUGHOUT for all answers.

New Baby Registrations

- If you are filling this form in for a New Baby, please only complete **Section A, F, G & H as applicable** and sign the declaration on page 6 on behalf of the patient.

Adults and Children previously registered elsewhere

- For all other registrations please complete **SECTIONS A-G** as fully as possible.
- We will need proof of your **NAME & ADDRESS** so please provide one of the following: Birth Certificate, Driving Licence, Passport, Utility Bill, Allowance Book, Solicitors Letter, Offer of Tenancy, other official document with your **NAME & ADDRESS** on.
- We **CANNOT** register you without the name of your previous doctor/surgery so please ensure you provide this information. Please sign the Declaration on **page 6** or sign on behalf of children under the age of 11.

Online Access to Medical Records

- This section is optional. Please read it carefully before completing if you do require online access.

If you require help completing the form, please ask at reception.

SECTION A - use BLOCK CAPITALS THROUGHOUT for all answers

Title	Mr/ Mrs/Miss/Ms/Dr/Other:	**First name**	
Surname		**Previous Surname**	
Address			
		Post Code	

Marital Status Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐

Civil Partner ☐ Cohabiting ☐ Prefer not to answer ☐

Date of Birth D D / M M / Y Y Y Y **Gender -** Male ☐ Female ☐

Mobile Phone

Which is your preferred contact number -

Home Phone Home ☐ Mobile ☐ Work ☐

Work Phone No phone contact ☐

Do you consent to your mobile number being used for the purposes of text message appointments and health care promotions by the surgery? You can opt out of this at any time and we will not pass your number on to any third parties. No patient identifiable information is sent by text message. We have no facility to reply to messages. Yes ☐ No ☐

Email address

Do you consent to us contacting you via this email address Yes ☐ No ☐

Your Next of Kin - First name Surname

Next of Kin's Date of birth D D / M M / Y Y Y Y

Next of Kin's Phone number

What is your relationship with this person, e.g. husband/wife/family/friend/neighbour

FOR OFFICE USE ONLY – RECEPTION CHECKLIST

THESE CHECKS **MUST** BE COMPLETED & FORM INITIALLED **BEFORE** PASSING FOR SYSTEM INPUT

Proof of Identity and address provided	Birth Certificate		Driving Licence		Passport	
	Allowance Book		Solicitors Letter		Offer of Tenancy	
	Other (state)					
Reception: Please check all sections of the New Patient Questionnaire and GMS1 are fully completed, but especially:-						
New Patient Questionnaire	Section B		Section F		Section G (SCR)	
GMS1	Date of Birth		Previous address		Previous GP	
	If Immigrant, date entered UK provided		Admin: initial that all checks have been completed			

SECTION B

Previous GP Name & Address	

SECTION C

Height		Weight	

Carers / Support Workers, do you regularly care for someone?	Yes		No	
OR does someone regularly care for **you**?	Yes		No	

If Yes, please complete contact details	Full Name	
Contact Number		Their relationship to you	

Are you registered	Deaf		Blind/Partially Sighted		Disabled	

SECTION D

Are you a	Smoker		Ex-smoker		Never smoked	

If you DO smoke, approx. how many a day?		**Do you want to stop smoking?**	Yes		No	

If you do want to stop smoking, please contact Smoke Free Solutions for free advice and support on Freephone 0800 246 5343

Please tick appropriate box	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times a week
How often do you have a drink containing alcohol?					
	1-2	3-4	5-6	7-9	10+
How many units of alcohol do you drink on a typical day when you are drinking? (1 unit = small glass of wine or ½ a pint of beer; a single pub measure of spirits)					
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often have you had 6 or more units (female) or 8 or more units (male), on a single occasion in the least year?					
How often during the last year have you found you were not able to stop drinking once you had started?					
How often during the last year have you failed to do what was normally expected of you because of your drinking?					
How often in the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?					
How often during the last year have you had a feeling of guilt or remorse after drinking?					
How often during the last year have you been unable to remember what happened the night before because you had been drinking?					

	No	Yes, but not in the last year	Yes, during the last year
Have you or someone else been injured as a result of your drinking?			
Has a relative or a friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?			

SECTION E

Repeat Medication - please attach a copy of your repeat prescription if you have one Tick if attached [ ]

Family History - Please say who: Father, Mother, Brother, Sister, etc.:

Heart Disease		**Diabetes**	
High Cholesterol		**Stroke**	
Asthma		**Hypertension**	
Bowel Cancer		**Any other cancer**	
Heart Disease		**Diabetes**	

Living Will - This is not to be confused with a Last Will and Testament

Do you hold a Living will?* Yes [ ] No [ ]

*A Living Will is an advanced decision regarding your personal wishes in respect of medical intervention at the time of your end of life (i.e. resuscitation wishes). **If you have answered Yes, we require a copy for our records.**

SECTION F Patient Ethnic Origin Questionnaire

- This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.
- Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.
- Choose **ONE** section from A to F, and then **TICK ONE** box to indicate your background or specify where required.

A	White	British		Irish		Other White background			
B	Mixed	White & Black Caribbean		White & Black African		White & Asian		Other Mixed background	
C	Asian or British Asian	Indian		Pakistani		Bangladeshi		Other Asian background	
D	Black or Black British	Caribbean		African		Any other Black background			
E	Chinese or other ethnic group	Chinese		Other ethnic group					
F	Prefer not to answer								

Further Information / Continuation - Please use this space for continuation or any other issues you feel the doctor will need to know about you.

Please continue on page 11 if required

SECTION G – Summary Care Record

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 who 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.

- **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.

Once you have completed the consent form, please return it to your GP practice. You are free to change your decision at any time by informing your GP practice.

SECTION G – Summary Care Record

Summary Care Record Patient Consent Form

Having read the information on page 5 regarding your choices, please choose **ONE** of the options below:

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).

Name of patient			
Date of birth		Patient's Postcode	
Surgery name	Willowbrook Medical Practice	Surgery location (Town)	Sutton in Ashfield
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

For more information, please visit https://www.digital.nhs.uk/summary-carerecords/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	**CTV3 /** SNOMED Code
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	XaXbY 773031000000109
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	XaXbZ 773051000000102
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	XaXj6 777441000000102

Section H Choosing which organisations can view your record

Please read below then complete the form on the next page

Choosing which organisations can view your record

You can choose which other organisations involved in your care can view your full medical record. You can choose this on an individual organisation basis, or apply the setting across all organisations.

Speak to your GP to set your choice, or set them yourself using SystmOnline. You have the following choices:

I'm happy for my full patient record to be viewed by health and care organisation(s) involved in my care.

I do not want my patient data to be viewed by health and care organisation(s) involved in my care.

I would like to provide an extra security code, or online approval to health and care organisation(s) involved in my care in order to view my record.

How to provide a security code or online approval

Receive code via text - give this code to your healthcare professional

Receive code via e-mail - give this code to your healthcare professional

Approve the organisation using SystmOnline on your computer or phone

For more information, please speak to your GP.

Section H Choosing which organisations can view your record

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I, (forename) ______________ (surname) ______________

have been given the opportunity to discuss sharing of my patient record and have read and understood the information "**Choosing which organisations can view your record**".

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health.

Please tick ✓ **ONE** of the following options, I understand that I can change my decision at any time:

	✓ **I'm happy for my full patient record to be viewed by health and care organisation(s) involved in my care.**
	✗ **I DO NOT want my patient data to be viewed by health and care organisation(s) involved in my care.**
	− **I would like to provide an extra security code, or online approval to health and care organisation(s) involved in my care in order to view my record ✶**

✶You will need to have a mobile number, email address or SystmOnline access for this option. Please supply us with the mobile number or email address below, or register for SystmOnline:

Mobile											
Email											
SystmOnline	Please complete the form on page 9										

Signed ______________ **Date** ______________

OR

Patient representative ______________ Date ______________

Relationship to patient ______________

NEW PATIENT QUESTIONNAIRE DECLARATION

To the best of my knowledge, all of the answers and information provided are true and correct.

Signature		Dated	
Print Name			

Thank you for completing this Health Questionnaire. A Practice Booklet is available from reception with further details of the services offered at Willowbrook. You will be contacted IF we need to see you. If you require lifestyle advice, e.g. dietary advice, BP check, you are welcome to make an appointment for a Well Person check with a Practice Nurse.
Many thanks, WILLOWBROOK MEDICAL PRACTICE

THIS SECTION IS OPTIONAL unless you ticked ✶ on page 8

Application for Online Access to Medical Records

www.nhs.uk/patientonline

PLEASE READ FORM CAREFULLY and use BLOCK CAPITALS throughout

A. Patient Details

SECTION A. MUST BE COMPLETED FOR ALL REQUESTS
Please use one form per patient

Surname		Age	
First Name(s)		Date of Birth	D D M M Y Y Y Y
Home Address			
		Post Code	
Email address			
Mobile		Home no.	

By giving your mobile and/or email you are consenting to be contacted by SMS and/or email which may include medical information.

B. Tick only ONE

☐ **1) BASIC ACCESS -** Booking appointments, requesting repeat medication, view Summary Care Record, update address and contact details

This access can usually be given to you the same day. Please provide two valid forms of identification, one must be photo ID.

OR

☐ **2) ENHANCED ACCESS -** All of the Basic Access rights, plus:
Detailed Coded Record, i.e. allergies, medication, immunisations, results, procedure codes

Please provide two valid forms of identification, one must be photo ID.
You will need to return to the surgery in 7 working days to pick up login information.

C. Declaration

I wish to access my medical record online and understand and agree with the statement below:

I confirm I have read the information leaflet provided by the surgery and agree to be responsible for the security of the information that I see or download. I understand that if I choose to share my information with anyone else, this is at my own risk. I understand that I should contact the practice as soon as possible if I suspect my account has been accessed without my permission or unlawfully. I understand I will contact the practice should I see information that is not about me or is incorrect.

Patient Signature		**Date**	

If you are only requesting access to your own medical records you do not need to complete any further sections of this form.

Please see over for proxy/representative access.

This section is to be completed as appropriate, if a representative wishes to have proxy record access to the patient named in Section A on page 9.

D. Proxy / Representative Access

The patient named in SECTION A, wishes the proxy/representative named below to have access to the following online services:

Allow appointment booking	Yes / No	Allow medication requesting	Yes / No
Allow completing questionnaires	Yes / No	Allow viewing of summary record	Yes / No
Allow viewing of detailed coded record	Yes / No	Is this **Temporary Access**	*Yes / No
*If you want to grant temporary access only to your records, state the date you wish it to end	D D M M Y Y		
Preferred contact method	Home phone / mobile / letter / text message / no communication		

Proxy / Representative Information

Surname		**First name(s)**	
Phone no.		**Date of birth**	D D M M Y Y Y Y
Home Address		**Post code**	
Proxy/Representative relationship to the patient in **SECTION A** overleaf	Parent/Guardian/Carer/Other (specify):		

The proxy/representative must also be registered to use online services:

- If proxy/representative IS a registered patient at THIS PRACTICE and NOT registered for SystmOnline, the proxy/representative must complete a separate online registration form (Section A-C) and attach it to this form.
- If the proxy/representative IS NOT a patient at this practice, the proxy/representative will be issued with a SystmOnline account user name and passphrase to allow access.

Tick if Attached ☐

DISCLAIMER

- If patient in Section A is aged 11 or over, they **must** sign this disclaimer below. *Please be aware that from the patient's 16th Birthday, **all proxy** access will be automatically revoked.*
- If patient in Section A is aged under 11, we do not require their signature, only the representative[ℓ].
- If patient in Section A is unable to sign themselves, please sign and print your name below[ℓ].

The patient named in SECTION A, consents to the above named person having proxy access to my medical records. I understand that I can change my mind about this at any time and if I wish to do so must contact the surgery and tell them the reason.

PATIENT Signature required for ages over 11 years		Date	
OR ℓSignature of person representing patient		Date	
Print name if representative of the patient			

FOR PRACTICE USE ONLY

Patient NHS Number				**Photo ID and proof of residence**	
Identity verified by (initials)		**Date**		**Vouching with information in record**	
				Vouching	

Level of PATIENT access granted	**Basic** (appointments/medication/questionnaires/SCR) ☐ **Detailed** (appointments/medication/questionnaires/SCR/detailed-coded) ☐*		
	***Detailed Name of GP Authorised**		**Date**
PROXY ONLY	***Relationship to Patient***		
Basis for granting access	*Patient consent (verbal)* ☐ *Patient consent (written)* ☐ *Parental responsibility* ☐ *Patient lacks capacity (court order)* ☐ *Patient lacks capacity (power of attorney)* ☐ *Patient lacks capacity (patient's best interests)* ☐		
PROXY ONLY Access Granted	*Appointments* ☐ *Medication* ☐ *Questionnaires* ☐ *SCR* ☐ *Detailed Coded* ☐ *NOT GRANTED* ☐		
Date account created & passphrase sent		**Authorised by (admin)**	

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