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 **Sections A, F, G & H** as applicable and sign the declarations on page 8 on behalf of the patient.

Adults and Children previously registered elsewhere

- For all other registrations please complete **SECTIONS A-H** 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 Declarations on **page 8** or sign on behalf of children under the age of 11.

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

Do you have a smartphone or tablet?

If so, you can book, cancel and check your appointments, order your repeat medication and much more.
If you would like access to this you can **self register** when you have downloaded the NHS App from the Apple App Store or Google Play.

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 Page 2		Section F Page 4		Section G (SCR) Page 6	
GMS1	Date of Birth		Previous address		Previous GP	
	If Immigrant, date entered UK provided on GMS1		Admin: initial that all checks have been completed			

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 – USE BLOCK CAPTIALS

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

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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:** *Cigarette, Cigar, other*		**Smoker:** *e-Cigarette*		**Smoker:** *Cigarette & e-Cigarette*		Ex-smoker		Never smoked tobacco	

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 visit **quitnow.smokefree.nhs.uk**

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?			

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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**	

Do you have any allergies or sensitivities

Living Will - This is <u>not</u> to be confused with a Last Will and Testament

Do you hold a <u>Living will</u>?* 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	☐								

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

Please attach additional information if required and state your name & date of birth on the attachment.

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.

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SECTION G

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	D D M M Y Y Y Y	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.

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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

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:

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☑ **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 <u>provide an extra security code, or online approval</u> 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.

▼ Now please complete the next page ▼

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/NHS App access for this option. Please supply us with the mobile number and/or email address below, or register for the NHS App:

Mobile	
Email - Please use BLOCK CAPITALS	
NHS App	Please download the smartphone/tablet app from Google Play or Apple App Store to register yourself.

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

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