

Please indicate the surgery that you are registering at:

St Anne's Surgery Beltinge and Reculver Surgery William Street Surgery Hersden Surgery

The Heron Medical Practice



New Patient Health Questionnaire & Out Of Area Registration Form Under 16

| PERSONAL DETAILS & SHARING INFORMATION | | | | | | | | | | |
|---|----|--|--|--|------|--|--|--|---------------------|--|
| Title | Mr | | | | Miss | | | Other | Date of Birth | |
| Surname | | | | | | | | | NHS Number | |
| First Name | | | | | | | | | Occupation | |
| Next of Kin | | | | | | | | | Relationship To You | |
| SHARING INFORMATION & MEANS OF CONTACTING YOU ** | | | | | | | | | | |
| In accordance with the Data Protection Act, the Practice requires consent to enable us to leave messages, send text message reminders and speak to a third party (i.e. next of kin or your carer) about your medical care. | | | | | | | | | | |
| Address: | | | | | | | | PLEASE TICK if you consent to the practice leaving you answer phone messages or text reminders or contacting you by your email. | | |
| Tel No: | | | | | | | | | | |
| Mobile: | | | | | | | | | | |
| Work: | | | | | | | | | | |
| Email: | | | | | | | | | | |
| I consent for the practice to leave messages concerning my medical treatment e.g. cancelled appointments with: <ul style="list-style-type: none"> If you wish to give consent for a third party to have access to your medical records please ask reception for a separate consent form. | | | | | | | | | | |
| COLLECTING PRESCRIPTIONS ** | | | | | | | | | | |
| Any patient wishing for a third party to collect their prescription will have to provide consent. | | | | | | | | | | |
| I give consent for _____ to collect my prescription on my behalf. | | | | | | | | | | |

***This consent will remain in force until further notice or cancellation by me.**

| CONSENT |
|---|
| <p>If you are registered with a GP practice in England, you will have a Summary Care Record (SCR) unless you have chosen not to have one. Your SCR contains the following basic information: the medicines you are taking , your allergies ,bad reactions you may have to certain medicines. It also includes your name, address, date of birth and unique NHS Number helps to identify you correctly.</p> <p>An SCR is used in a number of healthcare settings and will provide healthcare professionals with any information they wouldn't otherwise have. For example, when you're visiting an urgent care centre or being admitted to hospital, staff could view your SCR and discover you are on a particular medication or have allergies.</p> <p>If appropriate, you/health professionals can choose to add any information to your SCR that you think will help improve your care. This can be of particular benefit to patients with detailed and complex health problems. You and/or your carer</p> |

should discuss anything you wish to add with your GP. Only authorised healthcare professionals directly involved in your care can access your SCR. Your SCR will not be used for any other purposes.

All patients registered at St Anne's Group Practice are recorded as 'implied consent medications, allergies and adverse reactions only'. This will remain on your record until you make an express choice. If you would like further information please contact reception or visit <https://digital.nhs.uk/summary-care-records>

| Please select one from below: | | |
|--|-----------|--|
| I give express consent for my Summary Care Record – medications, allergies and adverse reactions only | Name | |
| | Signature | |
| | Date | |
| I give express consent for my enriched Summary Care Record - medications, allergies and adverse reactions AND additional information | Name | |
| | Signature | |
| | Date | |
| I am unsure about Summary Care Records and would like to decide after further discussion – remaining as implied consent until I notify the practice otherwise. | Name | |
| | Signature | |
| | Date | |
| I DO NOT give my express consent – Opted out | Name | |
| | Signature | |
| | Date | |
| Other please specify ... | | |

| ETHNIC GROUP | | | | | |
|--------------|------------------------|--|--------------|-------------------------|--|
| White | British | | Black | Caribbean | |
| | Irish | | | African | |
| Asian | Indian | | Other | White & Black Caribbean | |
| | Pakistani | | | White & Black African | |
| | Chinese | | | White & Asian | |
| | | | | Arab | |
| | Other (Please specify) | | | Prefer not to answer. | |

| LANGUAGE & COMMUNICATION | |
|---|----|
| Please indicate your first language | |
| Do you speak a second language? | |
| If English is not your first language, would you need an interpreter during a consultation? | ** |
| OTHER WAYS WE CAN HELP | |
| The practice is always looking at ways to improve the way in which we communicate with our patients, if you have a disability, impairment or sensory loss please let us know so that we can better help you access and understand the information and correspondence from the practice. Examples of support would include emails, text messages, sign language interpreters, lip-reading, audio, braille, easy read or large print etc. For more information please ask at the reception desk or visit www.england.nhs.uk/accessibleinfo | |
| Do you have any information or communication needs? | ** |

If yes please give details:

OTHER INFORMATION

| | | | | |
|--|-----|--|----|--|
| Are you registered disabled? | Yes | | No | |
| If yes please give details of your disability: | | | | |

| | | | | |
|--------------------------------------|-----|--|----|--|
| Do you have a carer? | Yes | | No | |
| Are you a carer? | Yes | | No | |
| Do you have a social worker? | Yes | | No | |
| Do you live in a care home? | Yes | | No | |
| Are you an asylum seeker or refugee? | Yes | | No | |
| If yes, please give details: | | | | |

If you are a carer please ask for a carer’s questionnaire at the reception desk, thank you.

MEDICAL INFORMATION

| | | | | | | | |
|---|-----|--|----|--------------------|-----|--|----|
| Have you ever suffered from? (tick as appropriate) | | | | | | | |
| Epilepsy | Yes | | No | Blindness/Glaucoma | Yes | | No |
| High Blood Pressure | Yes | | No | Diabetes | Yes | | No |
| Heart Attack/Stroke | Yes | | No | Depression | Yes | | No |
| Cancer | Yes | | No | Asthma | Yes | | No |
| Eczema | Yes | | No | Hay Fever | Yes | | No |

You are invited to make an **appointment for a new patient check**, where your medical history will be discussed, in the meantime are there any serious illnesses, operations, accidents or disabilities you think we should be aware of beforehand?

Your height:

Your weight:

Are you **allergic** to any medicines and if so, which?

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

FAMILY HISTORY

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease:

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

SMOKING STATUS (14+ only)

| | | | | | | |
|--|-----|--|----|--|--|--|
| Are you a current smoker? | Yes | | No | | If yes how many cigarettes or ounces of tobacco per day? | |
| Would you like advice on giving up smoking? | Yes | | No | | | |
| Are you an ex-smoker? | Yes | | No | | If yes how many cigarettes or ounces of tobacco per day? | |
| | | | | | When did you stop? | |

YOUR HOUSEHOLD

Please give details of parents/guardians who are also registered at this practice

| Name | Relationship to you |
|------|---------------------|
| | |

| | |
|---------------------------|--|
| Print Name: | |
| Patient Signature: | |
| Date: | |

Out of Area Patients

New arrangements introduced from January 2015 give people greater choice when choosing a GP practice. Patients may approach any GP practice, even if they live outside the practice area, to see if they will be accepted on to the patient list.

The new arrangements mean GP practices now have the option to register patients who live outside the practice area but without the obligation to provide home visits.

Out of area is voluntary for GP practices meaning patients may be refused because they live out of the area.

If your application is considered the GP practice will only register you without home visits, if it is clinically appropriate and practical in your individual case. To do this we may:

- Ask you or the practice you are currently registered with questions about your health to help decide whether to register you in this way.
- Ask you questions about why it is practical for you to attend this practice (for example, how many days during the week you would normally be able to attend)

If accepted, you will attend the practice and receive the full range of services provided as normal at the surgery. If you have an urgent care need and the surgery cannot help you at home we may ask you to call NHS111 and they will put you in touch with a local service (this may be a face to face appointment with a local healthcare professional or a home visit where necessary).

We may decide that it is not in your best interests or practical for you to be registered in this way. In these circumstances we may offer you registration with home visits for example if you live just outside the practice area or we may not register you and advise you should seek to register (or remain registered) with a more local practice.

If accepted but your health needs change we may review your registration to see if it would be more appropriate for you to be registered with a GP practice closer to your home.

This new arrangement only applies to GP practices and patients who live in England.

For further information visit the NHS Choices website www.nhs.uk

If you are registering as an out of area patient please complete the section below and return the completed form to the practice along with your New Patient Health Questionnaire and completed GMS1

Full Name.....

Date of Birth.....

Home Address.....

.....

.....

Telephone/Mobile Number.....

E-mail address.....

I confirm I have read the Out of Area patients information and I am aware that the GP practice is not obligated to carry out home visits

Signed:.....

Print Name:.....

I confirm I have read the Out of Area patients information and I am aware that if my health needs change the practice may advise it may be more appropriate for me to be registered with a GP closer to my home

Signed:.....

Print Name:.....