Riverside Family Practice

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Welcome to Riverside Family Practice

We are pleased that you have an interest in registering with our practice. In order to become a patient and successfully complete the registration the following requirements must be met:

1. You must:
    - Complete the GMS1 form and the 'new patient health questionnaire'
    - Ideally have proof of ID and address
    - Ideally provide a list of current medications

2. You are required to attend an initial registration appointment with our Practice Nurse or Healthcare Assistant. This will make sure that our records are accurate and all routine checks to promote your health and wellbeing (such as blood pressure/smear tests/mammograms) are up to date.

Please allow 2 working days for your registration to be processed. If you require an urgent appointment during this period, please inform us at first contact.

For children under 5 years the red book needs to be provided. This is needed so we have records of the child's baby immunisations and NHS number.

Without the above information we may not be able to register you in a timely manner.

Drugs of Dependence Policy - New Patients

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis. A list of the most commonly encountered controlled drugs:

Opiates	Other Drugs of Dependence include:
Morphine	**Pregabalin**
Oxycodone	**Gabapentin**
Fentanyl	**Temazepam**
Buprenorphine	**Nitrazepam**
Codeine	**Diazepam**
Dihydrocodeine	**Lorazepam**
Tramadol	**Zopiclone**
Tapentadol	**Zolpidem**

New Patients: Please inform staff if you are prescribed any of the above medication.

Some of our patients require strong, potentially addictive medication to help manage their condition(s). Of concern are 'drugs of dependence' (e.g. opioid medications and benzodiazepines), particularly when these are prescribed on an on-going basis.
Due to increasing reports of abuse of prescription drugs Riverside Family Practice has established a policy to ensure adequate treatment of your condition, while reducing the risk of problems with drug prescriptions.

If you are a new patient to the practice:
It may take time to get accurate medical information about your condition. Until such information is available, your GP may choose not to prescribe any medication. It is our policy that GPs do not prescribe drugs of dependence until they have a full clinical picture.
Your GP may decide not to continue prescribing an opioid medication previously prescribed for you. It may be determined that such a medication is not suitable. It is our policy that GPs do not prescribe drugs of dependence if they feel that previous prescriptions were inappropriate.
Your GP will evaluate your condition and only prescribe an opioid of the strength necessary for you. This may be different to the drug you had prescribed at your previous GP Practice.

General practice standards:
If the decision to prescribe is taken after a shared discussion of goals, plans, risks and benefits, you may be required to confirm your consent in writing.
You will be asked to complete the **Opioid Management Plan: Treatment Agreement** that will detail our practice's expectations when prescribing drugs of dependence. This agreement details your responsibilities as a patient taking a drug of dependence; any prescriptions issues; advice on taking your medications; how we will monitor your care; and the standards of behaviour that are expected.

Patients may need to acknowledge that their care requirements may be complex, and that referral for on-going care for all or part of your healthcare may be required. It is our practice policy that patient care is matched with the level of complexity.
Patients are reminded that we have a zero tolerance on issues relating to staff abuse.

Please sign below to agree to this practice policy

Signature Date

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New Patient Health Questionnaire

Your contact details	
Title:	Surname:
Date of Birth:	First Name(s):
Occupation:	Previous Surname:
Home Address:	Home Telephone:
	Mobile Telephone:
Email Address:	

Information About You			
Height:		Weight:	
First Language:		Do you need an interpreter? Yes/No	
What is your ethnicity?			
White:	☐ British ☐ Irish ☐ Other (Please specify):		
Black:	☐ Caribbean ☐ African ☐ Other (Please specify):		
Asian:	☐ Indian ☐ Pakistani ☐ Chinese ☐ Other (Please specify):		
Mixed:	☐ White & Black Caribbean ☐ White & Black ☐ White & Asian ☐ Other (Please specify):		

Medical Information	
Please list any serious illness/operations/accidents/disabilities (and for women any pregnancy related problems) and the year of diagnosis/took place:	
Have you ever suffered from any of the following? (tick all that apply)	
○ Epilepsy ○ Blindness/Glaucoma ○ High Blood Pressure ○ Diabetes ○ Heart Attack / Stroke	○ Cancer ○ Asthma ○ Eczema / Hay fever ○ COPD

If yes, please state the year(s) you were first diagnosed:
Please list any medication being taken and the amount or attach a copy of your repeat medication list:
Are you allergic to medication and if so, which?
Are you registered disabled? If yes, please give details:
Have you ever suffered from any of the following? (tick all that apply) ○ Anxiety ○ Depression ○ OCD ○ Bipolar disorder
If yes, please state the year(s) you were first diagnosed:
Do you have any other mental health issues? (if yes please give details)

For Women Only	Have you ever had a cervical smear? Yes/No
	If yes, when was it and what was the result?

Carers	
Do you have a carer? Yes /No	Are you a carer? Yes / No

Smoking	
Do you smoke? Yes / No	If no, have you ever smoked? Yes / No
If yes, how many cigarettes / ounces of tobacco do you smoke per week?	Would you like advice on giving up smoking? Yes / No

Alcohol						
Questions	Scoring System					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, in the last year	

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.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **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.

c) **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.

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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).

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.