**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

1. 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.

**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): | | |

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| --- | --- | --- |
| **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.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **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.
3. **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.

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.