**Thank you for registering with Headland Medical Centre**

**Your appointment for your New Patient Health check is on:**

|  |  |  |
| --- | --- | --- |
| Date | Time | Location |
|  |  |  |

It is important that you attend this health check to enable us to complete the registration process.

Please find attached forms which you will need to complete and bring to your appointment:

* Patient-Doctor Agreement
* Prescribing Agreement
* Patient Questionnaire
* Summary Care Record – Opt-in/Opt-out Form.

**If you are on any regular medication from your previous GP, please bring a copy of your repeat slip with you when you attend your new patient registration appointment**

If you are interested in applying for online services, please ask a member of staff in reception after your new patient check.

**PATIENT – DOCTOR AGREEMENT**

**STRICTLY CONFIDENTIAL**

|  |
| --- |
| Name: |
| Address: |
|  Postcode:  |

I confirm that I shall comply with the following conditions

1. I shall not make inappropriate use of the emergency appointment system.

2. I shall attend any appointment on time or notify the practice prior to the appointment if I am unable to attend.

3. I shall keep any arranged appointments at hospital or other secondary care provider.

4. I shall follow the treatment plan and advice given by my GP.

5. I shall not make inappropriate use of the out-of-hours emergency service.

6. I shall behave in a reasonable manner towards all staff and doctors at the surgery.

I understand that any breach of the above conditions will result in my removal from the practice list.

|  |  |
| --- | --- |
| Signed:(Patient)Please Print Name:  | Dated: |
| Signed:(GP)Please Print Name:  | Dated: |

**PRESCRIBING AGREEMENT**

**NOTICE FOR PATIENTS WISHING TO REGISTER WITH THE PRACTICE**

***All patients wishing to register with Headland Medical Centre, must read the information below and show their agreement by signing where shown.***

Headland Medical Centre has very strict guidance for its prescribers on the supply of medicines of which may be misused. All of our Doctors, Nurses and Pharmacists work according to this guidance. This follows national and local advice around the safe prescribing of such medication.

This means patients who are currently taking any of the following medicines will be asked upon joining the practice to start and complete a programme of reduction:

**Alprazolam Chlordiazepoxide Clonazepam Diazepam Flurazepam Loprazolam**

**Lorazepam Lormetazepam Nitrazepam Oxazepam Temazepam Zolpidem**

**Zopiclone Buprenorphine Co-Codamol Co-Dydramol Codeine Fentanyl**

**Morphine Dihydrocodeine Oxycodone Meptazinol Pethidine Tapentadol**

**Tramadol Hydromorphone Gabapentin Pregabalin**

This is because there are increasing safety concerns about these kinds of medicines when they are taken over long periods of time as they may cause a range of harmful side effects. They can also cause tolerance and can be addictive. For these reasons repeated use of them over a long time can no longer safely recommended.

Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to join Headland Medical Centre on the understanding that I will be expected to follow a reduction programme if I am currently taking any of the medication listed above.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT QUESTIONNAIRE**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth: |  |
| Address: |  | NHS Number: |  |
|  |  | Home Tel No: |  |
| Postcode: |  | Mobile Tel No: |  |

|  |  |
| --- | --- |
| Ethnic Origine.g., White/British, Black Caribbean |  |

**Past Medical History / Family History**

|  |
| --- |
| Do you suffer from or is there a family history of any of these problems? If yes, please give details: |
| Diabetes | YES / NO |  |
| Asthma | YES / NO |  |
| Epilepsy/Fits | YES / NO |  |
| High Blood Pressure | YES / NO |  |
| Heart Disease | YES / NO |  |
| Stroke | YES / NO |  |
| Allergies | YES / NO |  |
| Drug Abuse | YES / NO |  |

**Medications**

|  |  |
| --- | --- |
| Do you take medication regularly  | YES / NO If yes, please list below |
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**Smoking Status**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you smoke?  | YES / NO / EX | If an ex-smoker -how long did you smoke? |  | If YES - how many per day and for how many years? |  |

*(If you gave up smoking for more than 3 months, please let us know and we can amend your records)*

**Alcohol Questionnaire**

|  |  |
| --- | --- |
| Do you drink alcohol? | YES / NO If yes, please complete the following self-assessment survey: |
| Questions | Scoring System | Your Score |
|  | 0 | 1 | 2 | 3 | 4 |  |
| *How often do you have a drink that contains alcohol?* | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| *How many standard alcoholic drinks do you have on a typical day when you are drinking?* | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| *How often do you have 6 or more standard drinks on one occasion?* | Never | Less than monthly | Monthly | Weekly | Daily or Almost Daily |  |

***A TOTAL OF 5+ INDICATES HAZARDOUS OR HARMFUL DRINKING.***

**Vaccination History**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of last Tetanus vaccination: |  | Date of last Polio Vaccination: |  |
| Childhood Immunisations: | Diphtheria/Tetanus/Whooping Cough/Polio | Date: |  |
|  | MMR | Date: |  |
|  | Hib | Date: |  |
|  | Rubella | Date: |  |
| **Other Medical Questions** |  |
| When was your last smear? |  |
| Have you had any contact with HIV? |  |

**Communication Needs**

Do you have communication needs? Please circle: Yes / No (If yes, please state below)

British Sign Language………………………………………………………………………………....

Blind/Visual impairment…………………………………………………………….………………….

Translator…………………………………………………………………………………………………

Other: Please state………………………………………………………………………………………

|  |  |
| --- | --- |
| Do you give consent to receive text messages? | YES / NO |

|  |  |
| --- | --- |
| Have you ever served in the armed forces?End of service date (if applicable) | YES / NO |

|  |  |
| --- | --- |
| How did you find out about the Practice? |  |

|  |  |
| --- | --- |
| Are you a Carer? | YES / NO |

**For children & young people:**

|  |  |
| --- | --- |
| Are you a ‘Looked After Child’? | YES / NO |
| Are you in Foster Care? | YES / NO |
| Are you subject to a Child Protection Plan? | YES / NO |
| What is the name of your Social Worker? |  |
| What is the name of your Health Visitor? |  |

**Who has parental responsibility?**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship: |  |
| Address: |  |  |  |
|  | Home Tel No: |  |
| Postcode: |  | Mobile Tel No: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship: |  |
| Address: |  |  |  |
| Home Tel No: |  |
| Postcode: |  | Mobile Tel No: |  |

**Patient Declaration (to be completed by all patients)**

The answers to these questions are accurate to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Dated: |  |

**SUMMARY CARE RECORD**

|  |
| --- |
| Patient Name: |

Headland Medical Centre offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record is being introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

**What is the NHS Summary Care Record?**

The Summary Care Record will contain basic information about any **allergies you may have, unexpected reactions to medications and any prescriptions you have recently received.** The intention is to help clinicians in Accident and Emergency Departments and ‘Out of Hours’ health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

**Children under the age of 16**

Patients under 16 years will not receive this letter but will have a Summary Care Record created for them unless the GP surgery is advised otherwise. **If you are the parent or guardian of a child, then please make this information available to them or decide and act on their behalf.**

**Opt-in or Opt-Out**

You are strongly recommended to consider this choice. If you decide to proceed and have a Summary Care Record created, and at any time in the future you change your mind and choose not to have a Summary Care Record, all you need to do is write to the surgery informing us of your decision to ‘Opt Out’, or print off the “Opt-out” form from the scrtees@nhs.net website and take or post it to your surgery. If you wish to “Opt-out” now, follow the same process.

**If any of your Medical Information was marked private at your previous surgery, you will need to make the Practice aware, so we are able to mark your record private once again.**

**Please tick the appropriate box below and return this form to the surgery**:

**Yes**, I would like to have a Summary Care Record

**No**, I would not like to have a Summary Care Record

|  |
| --- |
| **Signed: Dated:** |

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname: | Date of birth:  |
| First name:  |
| Address:  |
| Email address:  |
| Tel:  | Mobile:  |

 **I wish to have access to the following online services (please tick all that apply):**

|  |  |
| --- | --- |
| 1. Booking appointments
 | ❑ |
| 1. Requesting repeat prescriptions
 | ❑ |
| 1. Access to detailed coded medical records only
 | ❑ |

**I wish to access my medical record online and understand and agree with each statement (tick)**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | ❑ |
| 1. I will be responsible for the security of the information that I see or download
 | ❑ |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | ❑ |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | ❑ |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 | ❑ |
| 6. I understand if I abuse the online system my access will be revoked. |  ❑ |
| **Signature:** | **Dated:** |

**For practice use only**

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by:(initials) | Date:  | Method Vouching ❑Vouching with information in record ❑ Photo ID and proof of residence ❑ |
| Authorised by:  | Date |
| Level of record access enabled Contractual minimum 🗹Other: ……………………………….… | Notes / explanation |

**Online Access - Patient Information Leaflet**

Practices are increasingly enabling patients to be able to request repeat prescriptions and book appointments online. Some patients may wish to access more information online and contractually from 1st April 2015 practices are obliged to assist access to medications, allergies and adverse reactions as a minimum and from the 1st April 2016 coded data.

However, this requires additional considerations as outlined in this leaflet. You will be asked that you have read and understood this leaflet before consenting and applying to access your records online. The practice will also need to verify your identity.

**Please note:**

* **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**
* **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**
* **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**
* **The practice may not be able to offer online access due to several reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

|  |
| --- |
| ***Key considerations*** |
| ***Forgotten history*** There may be something you have forgotten about in your record that you might find upsetting. |
| ***Abnormal results or bad news*** If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.  |
| ***Choosing to share your information with someone*** It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure.  |
| ***Coercion*** If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| ***Misunderstood information*** Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.  |
| ***Information about someone else*** If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |