Selsey Medical Practice

New Patient Registration

Welcome to Selsey Medical Practice.

Registering – what you need to fill in and hand back to us:

- Purple GMS1 registration form
- New patient form
- Proof of identity (passport / driving license / birth certificate / marriage certificate)
- Proof of identity (Council tax bill / utility bill / tenancy agreement / bank statement)
- Proof of medication (a copy of a recent repeat medication slip from your previous GP)

Information for you to keep:

- Practice booklet
- Your data – what you should know
- Friends of Selsey Medical Practice leaflet

Other information available in the surgery / on our website at www.selseymedicalpractice.co.uk

- Online access information & request form
- Information about our patient participation group
- Information and joining form for "Friends of Selsey Medical Centre"
- Carers leaflet
- Practice policies
- General information about the practice
- Self-help information and guides
- Practice Privacy Notices

www.selseymedicalpractice.co.uk

IF YOU REQUIRE A COPY IN A LARGER FONT OR ANOTHER FORMAT PLEASE ASK.

Selsey Medical Practice New Patient Registration Form

Please complete this confidential questionnaire
Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.
Please complete a separate form for each family member to be registered.

Contact Details	
Full Name:	**Date of birth:**
Ethnicity:	**First Language:**

Telephone Number:	**Mobile Number:**
Work Number:	**E-mail Address:**

Consent to use your data

I give my consent for my details being used in the following ways:

(please tick ✓ as appropriate)	**Yes**	**No**
Text messages relating to your medical care (e.g. appointment reminders / test results)		
Text / email / letter asking you if you would be willing to take part in medical research		
Email / text to ask you to take part in a survey about the practice		
Email you to send a copy of the practice newsletter		

Signed …….. Date …….

Please speak to Reception if you wish to update these arrangements in the future.

For Office Use:
☐ **Preferences applied.**

Have you ever served in the armed forces? YES/NO
If YES please add your service number:

Please indicate where you would like your prescriptions sent to:			
Lloyds Selsey	Boots Selsey	Collect from surgery	Other (please specify):

Do you consider yourself to have a disability? YES/NO
If YES please state what type of disability you have:

Your Medical Background:	
What illnesses have you had & when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	

Please state any allergies and sensitivities you have:

Is there any known family history of the following (tick all that apply and include which family member):			
Asthma	Thyroid disorder	Diabetes	Heart problems
High blood pressure	Stroke	Cancer (specify type)	

Smoking (please tick):		
Never smoked	☐	
Ex-smoker	☐	Approximately how many did you smoke a day:
Smoker	☐	How many a day:

What is your height:		What is your weight:	

Women only:			
When was your last smear done?		**Was this at your GP Surgery?**	**Yes / No**
What was the result of the smear?			
Date of last mammogram (if applicable):		**Method of contraception (if used):**	

How often do you exercise?	No. times per week	Type(s) of exercise:	

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	If "Yes", please bring a written copy for your record
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	If "Yes", please state their name / address / phone number:

Is there any other important information about you that you would like us to know (please state below):

Other information:

Are you a Carer? Yes / No	If "Yes", please state the name / address / phone number of the person you care for:
Do you have a Carer? Yes / No	If "Yes", please state their name / address / phone number:

If you are a carer or have a carer please complete a Carers registration form which is available on our website or from the surgery.

NHS Summary Care Record with additional information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

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 an SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you. **You can choose** to have additional information included in your SCR, which can enhance the care you receive. This information 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
- Who should be contacted for more information about you

What to do next

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form

Name of Patient: ……
Date of Birth: …… Patient's Postcode: …….
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: ……

Capacity (Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

If you require any more information, please visit **www.hscic.gov.uk/scr/patient** phone HSCIC on **0300 303 5678**

Access to your GP Medical Record

Our Medical Record Computer System is set-up so that if you receive medical care from one of the organisations below, they can, with your explicit permission, gain access to your GP Medical Record, thus helping them in their care of you.

Community Nursing Team	Onecall & Echo	St Wilfrid's Hospice	GP Extended Access (MIAMI)	Bognor Minor Injuries Unit
The nurses and other health professionals who work in the community and visit patients at their home	The team who coordinate Urgent Care and End of Life Care in the community	The team who Provide Tailored End of Life Care in the Community & at their Chichester Hospice	The new Minor Injury & Minor Illness clinics providing additional GP Appointments	Emergency Nurse Practitioners who treat minor injuries in the Bognor War Memorial Hospital

These teams will be able to access your medical record if you have been registered with them to receive their services. They will also ask for your Explicit Consent to view your GP Medical Record when they first see or speak to you. If you say no, they should not access your record.

If you do not want one or more of these organisations to have this ability, please ask for a Sharing Dissent form from Reception. Please make such a decision carefully as it will mean that even if you subsequently gave them explicit consent, they would not be able to access your record until they have spoken to the Surgery. This would be delayed overnight and at weekends when the surgery is closed and potentially when they need such access the most.

Dissenting Access to your GP Medical Record

I do **NOT** want the following organisations to have the ability to view my GP Medical Record if I were to register for their service (please tick ✓ as appropriate):	
Community Nursing Team The nurses and other health professionals who work in the community and visit patients at their home	
Onecall & Echo The team who coordinate Urgent Care and End of Life Care in the community	
St Wilfrid's Hospice The team who Provide Tailored End of Life Care in the Community & at their Chichester Hospice	
GP Extended Access (MIAMI) The new Minor Injury & Minor Illness clinics providing additional GP Appointments	

I understand that this will mean that even if I subsequently gave these organisations explicit consent, they would not be able to access my record until they have spoken to the Surgery and this would potentially lead to delays especially overnight and at weekends.

Signed …….. Date ……

Please speak to Reception if you wish to update these arrangements in the future. Alternatively, you are able to personally update these settings if you are registered for Online Services.

For Office Use:
☐ **Preferences applied.** ☐ **Read Code XaNwT added to record.**

Code of Conduct for Patients

New patients registering at the practice will sign up to the Patient Code of Conduct. The Code of conduct for patients is also available on our website.

Persons attending the practice whether in person or by telephone should behave in a manner that respects the rights of others and the practice environment.

We ask that patients treat the doctors and all practice staff with courtesy and respect.

Please attend for appointments on time, checking in with the receptionist or on screen immediately on arrival. If you think you are going to be late please telephone our receptionist.

Please give at least 24 hours notice where possible if you need to cancel an appointment. In any case please let us know so that we may give the appointment to another patient and not waste the doctors / nurses time.

Patients should attend the health centre for consultations where ever possible in order to make the best use of health centre facilities and doctors/nurses time.

When a home visit is requested please give clear details of patient's name, address, telephone number and directions if not straightforward.

When a home visit is necessary please telephone before 10.30 Monday to Friday.

Please book an appointment with the doctor at least seven days before the repeat prescription review date expires.

Newly registered patients will be offered an appointment with the practice nurse so that a summary of their medical history is available to the doctor prior to receiving the medical record.

Please advise us immediately of any change of name/address/telephone number.

Patients have the right to transfer from our practice and register with another practice if they are unhappy with the service which we provide.

Patient Signature:		**Signature on behalf of Patient:**	
Date:		**Date:**	

Alcohol Audit Form

Name:	Date of birth:
Today's date:	

This is one unit of alcohol...

...and each of these is more than one unit

Please circle your answers

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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	

TOTAL SCORE:

SCORING:

If you score 5 or more please complete the questionnaire on the next page.

Additional questions - please circle your answers

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	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 needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after 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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
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, during the last year	

TOTAL SCORE:

For office use only:

	Action	Completed by (initial)
Check Patient Registered		
Consent for text messaging	Enter read codes Tick consent / dissent box	
Armed services	Read codes entered	
Preferred chemist	Check chemist on system	
Medical history	Record if electronic record not available	
Smoking, Height and weight, Alcohol consumption, Exercise	Record	
Additional summary care record sharing	Read code XaXbZ if consent given	
Carer	Send task to notify Carer Champion	