BILLINGE MEDICAL PRACTICE

New Patient Pack

BILLINGE MEDICAL PRACTICE

Welcome to Billinge Medical Practice. In order to register you with the practice as smoothly as possible please read the information enclosed in this pack and fill in all the information required. If you have not already done so then please make an appointment for a New Patient Medical with the Nurse or Health Care Assistant

Please bring all completed forms with you for your registration medical with the nurse or healthcare assistant.

Enclosed are:

- **Registration (GMS1) Form** – *Please complete.*
- **New Patient Contact Form & Questionnaire** – *Please complete.*
- **Summary Care Records Information Leaflet** – *Please read this leaflet carefully and complete the opt-in or opt-out form as appropriate.*
- **Vision Online Registration Form –** *Please complete.*
- **Checklist –** *Please check you have all the information you need for your registration.*

Please make sure that you attend your appointment for a New Patient Medical. If you do not attend then we will not be able to register you as a patient. If you do not attend without cancelling your appointment then you will not be able to register again at a later date. Please ensure that you obtain your NHS number from your previous GP if you do not know it. We will not be able to register you without it

Please also bring a urine sample with you to your registration medical. Appropriate containers are available from reception.

NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✓ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

First names

Date of Birth

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillence

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

* Not all doctors are authorised to dispense medicines

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

Version 01/02

Please see right re: Organ donation

NHS GSM1

NHS Organ Donation registration

I would like to join the NHS Organ Donation Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate.

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is: (only if different from above e.g. Your place of work)

Postcode:

To be completed by your doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An Audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorise Signature

Name

Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

BILLINGE MEDICAL PRACTICE

CONTACT SHEET

TITLE:	FORENAME(S):	SURNAME:
ADDRESS:		
		POSTCODE:

DATE OF BIRTH:	
TELEPHONE NUMBER:	
MOBILE NUMBER:	
E-MAIL ADDRESS:	
PRIMARY SPOKEN LANGUAGE:	
DO YOU NEED AN INTERPRETOR? :	YES ☐ NO ☐
HISTORY OF MILITARY SERVICE:	NONE ☐ PRESENT ☐ PAST ☐ RAF ☐ ARMY ☐ NAVY ☐
MARITAL STATUS:	MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐
NEXT OF KIN DETAILS : *(Please provide name, address & contact number)*	
ARE YOU A CARER?: *If so to whom and what are their problems?*	
DO YOU HAVE A CARER?: *If so please provide their name, address & contact number*	
REASON FOR MOVING GP PRACTICE:	

PLEASE PROVICE YOUR ETHNIC GROUP *(Please Tick):*			
British ☐	White & Asian ☐	Any other Asian ☐	Any other ethnic Group ☐
Irish ☐	Any other mixed ☐	Caribbean ☐	Not stated ☐
Any other white ☐	Indian ☐	African ☐	
White & Black ☐	Pakistani ☐	Any other Black ☐	
White & Black Asian ☐	Bangladeshi ☐	Chinese ☐	

BILLINGE MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

AS WE WILL NOT RECEIVE YOUR MEDICAL RECORDS FOR SOME WEEKS, PLEASE HELP US BY COMPLETING THIS QUESTIONNAIRE. PLEASE BRING IT WITH YOU WHEN YOU ATTEND YOUR REGISTRATION MEDICAL.

PLEASE ALSO BRING A URINE SAMPLE WHEN YOU ATTEND YOUR REGISTRATION MEDICAL

HAVE YOU EVER BEEN DIAGNOSED WITH A CHRONIC DISEASE?
(e.g. Coronary Heart Disease, Asthma, Diabetes, Hypertension, Stroke, COPD, Epilepsy, Thysoid Disorders, Dementia, Rheumatoid Arthritis, Osteoporosis, Parkinson's Disease etc.)

Yes ☐ No ☐ If Yes, Please give a description:

PLEASE LIST ANY **MAJOR** ILLNESSES OR OPERATIONS YOU HAVE HAD:
(Please Provide Dates)

PLEASE PROVIDE A LIST OF YOUR MEDICATION:
(Preferably please provide the Repeat Prescription Form from your previous GP. If not please provide full details including Doses and how often you take the medication)

PLEASE LIST ANY ALLERGIES / ADVERSE DRUG REACTIONS: *(Name the Drug and what the reaction was e.g rash etc)*
PLEASE LIST ANY HISTORY OF SERIOUS ILLNESSES IN YOUR FAMILY: *(e.g Heart Disease, stroke, high blood pressure, high cholesterol, diabetes, cancer etc.)*

WHAT IS YOUR OCCUPATION?:			
DO YOU SMOKE? : If Current Smoker How much every day?	NEVER SMOKED ☐	CURRENT SMOKER☐	EX-SMOKER ☐
	No. of Cigarettes:	No. of Cigars	Oz of Tobacco
DO YOU EXERCISE?: *(Please state type of exercise and how many hours per week)*			
ARE YOUR IMMUNISATIONS UP TO DATE?			

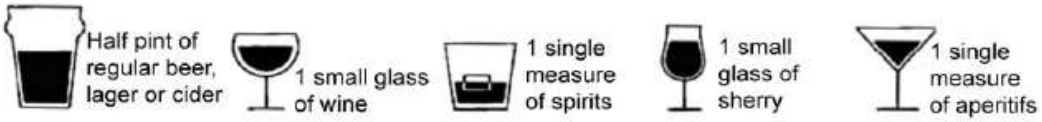
WOMEN ONLY	
ARE YOU CURRENTLY PREGNANT? :	Yes ☐ No ☐
HOW MANY PREGNANCIES HAVE YOU HAD (INCLUDING THE YEARS)? :	
WHEN WAS YOUR LAST CERVICAL SMEAR? :	

Please make sure that you attend your appointment for a New Patient Medical. If you do not attend then we will not be able to register you as a patient. If you do not attend without cancelling your appointment then you will not be able to register again at a later date.

BILLINGE MEDICAL PRACTICE

Please Complete the Following Alcohol Questionnaire:

This is one unit of alcohol...



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

AUDIT – C

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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

BILLINGE MEDICAL PRACTICE

This Page if for the Nurse / Health Care Assistant To Complete At Your Registration Medical:

EXERCISE GRADING:	Inactive ☐	Gentle ☐	Moderate ☐	Vigorous ☐
DIET: EATING HABITS	Poor ☐	Moderate ☐	Good ☐	
ALCOHOL AUDIT-C SCORE:	Score 5 to 15: Brief Intervention Given YES ☐ NO ☐		Score >15 : Referred to GP? YES ☐ NO ☐	
CHRONIC DISEASE REVIEW NEEDED?:				
OTHER HEALTH PROMOTION: *(e.g breast, testicular self examination, contraception, smoking cessation advice etc.)*				
BLOOD PRESSURE:		URINALYSIS:		
HEIGHT:		WEIGHT:		
SUMMARY CARE RECORDS: *(Please ensure the opt-in or opt-out form is signed)*		PATIENT WISHES TO OPT IN ☐		
		PATIENT WISHES TO OPT OUT ☐		

BILLINGE MEDICAL PRACTICE

Vision Online - Patient registration form

To register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.** Once you are registered the practice will give you the information that will enable you to create a username and password.

Patient details	Please complete in BLOCK CAPITALS
Patient forename	
Patient surname	
Date of birth	D D / M M / Y Y Y Y
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	D D / M M / Y Y Y Y
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	D D / M M / Y Y Y Y

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	D D / M M / Y Y Y Y

About Vision online services

We offer an online service for our patients so you can book your appointments and order your repeat prescriptions online at your convenience.

Online appointment booking

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don't need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

Request your repeat prescriptions online

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

hscic Health & Social Care Information Centre

Your Summary Care Record

Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those involved in your care with faster secure access to key information from your GP record.

What is a SCR?

If you are registered with a GP practice in England, you will already have an SCR unless you have previously chosen not to have one.
It includes the following basic information:

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

It also includes your name, address, date of birth and unique NHS Number which helps to identify you correctly.

What choices do you have?

You can now choose to include more information in your SCR, such as significant medical history (past and present), information about management of long term conditions, immunisations and patient preferences such as end of life care information, particular care needs and communication preferences.

If you would like to do this, talk to your GP practice as it can only be added with your permission.

Remember, you can change your mind about your SCR at any time. Talk to your GP practice if you want to discuss your option to add more information or decide you no longer want an SCR.

Vulnerable patients and carers

Having an SCR that includes extra information can be of particular benefit to patients with detailed and complex health problems. If you are a carer for someone and believe that this may benefit them, you could discuss it with them and their GP practice.

Who can see my SCR?

Only authorised care professional staff in England who are involved in your direct care can have access to your SCR. Your SCR will not be used for any other purposes.

These staff:

- Need to have a Smartcard with a chip and passcode
- Will only see the information they need to do their job
- Will have their details recorded every time they look at your record.

Care professionals will ask for your permission if they need to look at your SCR. If they cannot ask you because you are unconscious or otherwise unable to communicate, they may decide to look at your record because doing so is in your best interest. This access is recorded and checked to ensure that it is appropriate.

SCRs for children

If you are the parent or guardian of a child under 16, and feel they are able to understand this information you should show it to them. You can then support them to come to a decision about having an SCR and whether to include additional information.

Confidentiality

For information on how the NHS will collect, store and allow access to your electronic records visit NHS Choices at www.nhs.uk/records.

For more information talk to the staff at your GP practice or visit www.hscic.gov.uk/scr/patients
You can also phone the Health and Social Care Information Centre (HSCIC) on 0300 303 5678

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS Number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature .....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:
- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date .....

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Please ensure that you have completed the following and bring it with you for your New Patient Medical:

	Please tick: ✓
GMS2 Form Completed Including your NHS Number	
Completed New Patient Contact Form	
Completed New Patient Questionnaire	
Your Repeat Prescription Slip From Your Previous GP	
Completed Alcohol Questionnaire	
Completed Vision Online Registration Form (if required)	
Opt Out of Summary Care Record (if required)	
Urine Sample (Please Collect a Sample Container from Reception)	