

Patient's details

Please complete in BLOCK CAPITALS and tick ☒ as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of birth				First names
NHS No.				Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> 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 GP practice while at that address
	Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

	Postcode
Service or Personnel number:	Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

- ☐ I live more than 1.6km 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

<input type="checkbox"/> Signature of Patient	<input type="checkbox"/> Signature on behalf of patient
Date ____/____/____	

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- ☐ Any of my organs and tissue or
- ☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas

(The law recently changed and now everyone is signed up automatically unless you opt-out.)

Signature confirming my consent to join the NHS Organ Donor Register Date ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature confirming my consent to join the NHS Blood Donor Register Date ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: ____

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

Willow Tree Family Doctors

E84015

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name

Date

Practice Stamp

Willow Tree Family Doctors

343b Stag Lane

London NW9 9AD

Tel 0208 204 6464

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a)

☐ I understand that I may need to pay for NHS treatment outside of the GP practice
- b)

☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the Surcharge”), when accompanied by a valid visa. I can provide documents to support this when requested
- c)

☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS AND S1 FORMS

Do you have a <u>non-UK</u> EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period	(a) From: DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Now please email this form to the practice : patient.willowtreefamilydoctors@nhs.net

PATIENT QUESTIONNAIRE

Date of completing this questionnaire: ____ / ____ / ____

PERSONAL INFORMATION

FIRST NAME:		SURNAME	
PREVIOUS SURNAME(IF ANY):		D.O.B	
Contact No:		Mobile No:	
Email Address:		Occupation:	

We register all of our new patients for our online appointments booking/cancelling system if an email address is provided. Please tick here if you wish to opt out ☐

From time to time we send our patients emails containing surgery information. Please tick here if you would not like to receive these updates ☐

Text message reminders are sent to all of our patients that have provided a mobile telephone number. Please tick here if you do not wish to receive text reminders ☐

Next of kin Name:		Next of kin contact details:	
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Personal Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

ETHNICITY

To which ethnic group do you belong:

White British <input type="checkbox"/>	White Irish <input type="checkbox"/>	Other white Ethnic Group <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	Black African <input type="checkbox"/>
Black African and White <input type="checkbox"/>	Other mixed origin <input type="checkbox"/>	Polish <input type="checkbox"/>	Other Black Ethnic Group <input type="checkbox"/>	Caribbean <input type="checkbox"/>
Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other Asian ethnic grp <input type="checkbox"/>
Other ethnic grp – pls state.....				I do not wish to state my ethnic group <input type="checkbox"/>

RELIGION

Christian <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Hindu <input type="checkbox"/>	Jewish <input type="checkbox"/>
Muslim <input type="checkbox"/>	Sikh <input type="checkbox"/>	No religion <input type="checkbox"/>	
Do not wish to state my religion <input type="checkbox"/> Other _____			

LANGUAGE

Main Spoken Language:

English <input type="checkbox"/>	French <input type="checkbox"/>	Arabic <input type="checkbox"/>	Bengali <input type="checkbox"/>	Hindi <input type="checkbox"/>
Portuguese <input type="checkbox"/>	Polish <input type="checkbox"/>	Kutchi <input type="checkbox"/>	Urdu <input type="checkbox"/>	Spanish <input type="checkbox"/>
Russian <input type="checkbox"/>	Somali <input type="checkbox"/>	Gujrati <input type="checkbox"/>	Tamil <input type="checkbox"/>	

Other (Please State): _____ Do not wish to state my Language ☐

Do you need support with spoken English? Yes ☐ No ☐

I Speak English Well ☐ I Speak English Poorly ☐ I need an interpreter ☐
Sign Language ☐ Hearing aid ☐

CARER

Are you a Carer: Yes: ☐ No: ☐

OTHER

Are you any of the following:
Homeless ☐ Refugee ☐ Asylum seeker ☐

Do you have any disability?
No ☐ Yes ☐ please specify.....

How did you find out about this Practice?
Leaflet/Flyer ☐ Practice Website ☐ NHS Choices Website ☐ Google/Internet ☐ Word of mouth ☐
Referred by HC/UCC ☐ Re-registration ☐ Passing by ☐

Why did you leave your last GP?

What kind of accommodation you are living in currently?

Owner occupied ☐ / Private Rented ☐ / Council ☐ / Sheltered scheme ☐ / Housing Association ☐

Other: ☐ please specify.....



Pint of Regular
Beer/Lager/Cider



Alcopop or
Can of Lager



Glass of Wine
(175ml)



Single Measure
of Spirits



Bottle of
Wine

ALCOHOL SCREENING (FAST)

For the following questions please tick the answer which best applies.

1 drink=1/2 pint of beer or 1 glass of wine or 1 single spirits

(Please score 0 to 4 in the last column)

Questions	0	1	2	3	4	Score
MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>	
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No <input type="checkbox"/>	Yes, on one occasion <input type="checkbox"/>	Yes, on more than one occasion <input type="checkbox"/>			
TOTAL						

Why Screen

Alcohol consumption and alcohol problems exist as part of a continuum, from no or light usage to dependence. Hazardous, harmful and dependent alcohol use implicated in a range of physical and mental health conditions.

38% of men and 16% of women have an alcohol use disorder, and 6% of men and 2% of women have alcohol dependency. 20% of patients attending primary care clinics drink in an 'at risk' manner, although most of them go undetected.

Individuals drinking above recommended guidelines at greater risk of future health and social problems.

Excessive alcohol consumption associated with a range of offending behaviours including drink driving, assaults and related violent crime, domestic abuse.

Increase burden on health and social care systems:-

Often patients continue to be treated for alcohol related problems such as high blood pressure, depression or anxiety without being treated for the underlying alcohol problem. If alcohol misuse is identified and treated it could lead to a reduction in future alcohol related health problems, which could save on treatment costs, and decrease waiting times through a reduction in repeat admissions and consultations.

Early intervention has been shown to be effective in reducing prevalence of alcohol related problems by encouraging reduction in consumption levels.

Brief interventions were created as a method of tackling alcohol misuse in the early stages by encouraging excessive/hazardous drinkers to reduce consumption. A brief intervention can range from 5-10 minutes of information and advice given to an excessive drinker to 2-3 sessions of motivational interviewing or counselling.

Patient / Practice Agreement	
Disclosure	Repeat Prescriptions
I _____ below agree to disclose all material facts regarding my health to my General practitioner and his/her Clinical Staff. We the Practice declare that we shall not disclose any information regarding Patient without the Patient's written consent.	I agree to requesting Repeat Prescriptions giving the Practice <u>two working days notice</u> of my need for medication. Furthermore I agree to make my request either in person, by Fax or E-mail. I acknowledge that requests cannot be made by telephone (Exception for house bound patients if agreed by the practice).
Confidentiality	Telephone Results
We the Practice declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent.	I appreciate that I can telephone for results of medical tests between 11.30AM and 2.30PM. I agree to phone during the advertised times.
Appointments	Zero Tolerance
I agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time.	I agree with the policy of zero tolerance of abuse towards all <i>NHS</i> Staff and I agree NOT to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the Practice to remove me from their List without appeal should I behave in a manner prohibited.
Home Visits	Food/Drink
I shall only request a home visit from the Practice under circumstances where I cannot physically attend at the Practice; I will endeavor to make this request no later than 10:00 A.M.	I agree that in the interest of fellow Patients it is unacceptable to consume food/drink within the Practice building and I agree to observe this requirement at all times.
Out of Hours Services	Non NHS Services
I agree to avail of the Out of Hours Services ONLY where it is medically necessary, otherwise I shall wait until the following morning and contact the surgery.	I agree to pay fees for non NHS services (such as medical certificate for absences less than 7 days). I understand such services are not covered under the NHS.
Mobile Phones	Bringing Children
I agree to <u>switch off</u> my mobile phone before entering the Practice and to keep it switched off at all times while I am within the Practice building. If I forget to switch it off before entering the Practice building I agree to switch it off <u>immediately should it ring</u> while I am within the building.	If you need to bring children to the surgery, we would be grateful if you could ensure they do not disturb other patients.
<p>I agree with all the terms stated above.</p> <p>Print Name: _____ Signature: _____</p> <p>Date: _____</p> <p>The Practice thank you for signing this agreement.</p>	