WESTLANDS MEDICAL CENTRE NEW PATIENT REGISTRATION FORM

People over the age of 13 years old

Welcome to Westlands Medical Centre. Please complete the following forms. We pride ourselves on offering a high standard of care, and this information is extremely valuable in achieving this.

An administrator will be happy to assist you with any queries you may have. Bring the form with you along with suitable identification. Acceptable identification documents are shown in the list below.

IDENTIFICATION

Bank/building society cards/statements	☐	National Insurance number card	☐
Birth certificate	☐	P45	☐
Driving licence	☐	Paid utility bills	☐
Letter-Benefits Agency/benefit book/signing on card	☐	Papers from the home office	☐
Local authority rent card	☐	Passport	☐
Marriage certificate	☐	Payslip	☐
Medical card	☐		

A combination of any 2 the above documents ONLY can be accepted as identification.
You must produce one item of photo ID and one item containing your address (dated within last 3 months)

For office use only

Name confirmation Which document was seen?		**Date of document:**	
Address confirmation Which document seen?		**Date of document:**	
Staff member (write clearly)		**Today's date:**	

ABOUT YOU

Surname: ____________ **Forename(s)**: ____________

Gender: ____________ **DOB**: ____________

Address: ____________

____

Post code: ____________

Home Phone: ____________ **Work Phone:** ____________

TALKING TO YOU – PERSONALLY

It's important to you and us at Westlands that we only discuss medical information with the person who it is about and so we've made it our practice policy to only take the personal email addresses and phone numbers of people of 13 years of age and older.

If you are over the age of 13 and have a personal email address and phone number, we'd like you to tell us it here.

If you are a parent or guardian of a person age 13 to 16, we can't accept your email address and mobile phone number for your child.

If you have concerns about this, please ask to speak to a Manager.

Mobile Phone Number: ____________

Email Address: ____________

If you would like this form in an alternative format, for example large print or easy read, or if you need help communicating with us, for example because you use British Sign Language, please contact the Practice

CONFIDENTIAL (WHEN COMPLETE)

COLLECTING INFORMATION ABOUT ETHNIC GROUPS

Under the terms of the NHS Contract, the Practice is required to ask all new patients to describe their own ethnic group. This list is designed to allow most people to identify themselves. However, if you feel the categories do not describe your ethnic group, please let us know and we will enter 'any other group' together with details of how you would describe yourself (e.g. 'Cornish').

The reasons given for collecting this data are that 'information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.'.

If you choose not to complete the question we will assume that you have exercised your right to refuse to divulge your ethnicity.

Ethnic Groups

Please tick:

☐ Asian or Asian British – Indian

☐ Asian or Asian British – Pakistani

☐ Asian/Asian British – Bangladeshi

☐ Asian/Asian British – any other Asian background

☐ Black or Black British – Caribbean

☐ Black or Black British – African

☐ Black or Black British – any other Black background

☐ Chinese

☐ Mixed – White and Black Caribbean

☐ Mixed – White and Black African

☐ Mixed – White and Asian

☐ Mixed –any other mixed Background

☐ White – British

☐ White – Irish

☐ White – any other White background

☐ Any other ethnic group ________________________ Language(s) Spoken ________________________

Collecting information about Service Families & Veterans

Westlands recognises its responsibilities to Veterans and the families of Serving Armed Forces Personnel.

Are you a Veteran? ☐ No ☐ Yes (Please ask your administrator for a Veterans Registration Form)

Please let us know if you are a member of a Service Family. This will allow us to inform other healthcare providers so that you are not disadvantaged by having to move locations with your partner because of the needs of the Service.

Are you a member of a Service Family? ☐ No ☐ Yes

Are you on a waiting list in another place? ☐ No ☐ Yes

Which waiting list: ________________________ Which Hospital/Referral Place: ____________________

CONFIDENTIAL (WHEN COMPLETE)

CONSENT FORM FOR SERVICES –PLEASE READ CAREFULLY

Access to Online Services

If you have provided us an email address, we will automatically enrol you onto Systm1Online which is operated by System1 our IT clinical supplier. This will give you online access to part of your GP record, allow you book appointments and order repeat medication.

Please note:

- This will allow access to your medical records and you are responsibility for the security of the information you view or download.
- You must keep your password and logon secure and private.
- If I choose to allow other people access to this information I do so at my own risk.
- If I suspect my account has been accessed by someone without my agreement I will notify the practice immediately and request a new password.
- If I see information in my record that is not about me or is inaccurate, I will contact the Practice as soon as possible.

If you **DO NOT** want to receive a login and password to SystmOnline please tick this box here ☐

ELECTRONIC PRESCRIPTIONS

Westlands is an electronic prescribing practice and we are phasing out paper prescriptions where possible. You will need to nominate a pharmacy for us to electronically send all your prescriptions directly

I would like to nominate: ________________________________ Pharmacy, _____________ Branch _______________

Phone Messages, Email & Text Messaging Services

At Westlands, we use texts and emails to keep you informed about your appointments, important events such as Flu Vaccination Clinics and if there are issues & news about the in the practice (such as a power failure or illnesses).

Please be aware:

- Text messages do form part of your medical record, it is not an appropriate way for you to send clinical queries or seek urgent advice and you should contact the Practice if you need immediate help.
- Email is not a secure medium and there is a possibility that emails and the responses could be intercepted and read by someone else. Please bear this in mind in deciding how much information you seek/disclose it is not an appropriate way for you to send clinical queries or seek urgent advice and you should contact the Practice if you need immediate help.

We require your explicit consent to be able to communicate with you via any of these methods. You can withdraw your consent at any time.

I understand that I chose to use the following communication methods with Westlands Medical Centre. I confirm that I understand how these types of communication methods work, the type and purpose of

communication that is appropriate. I will comply with this and consent to how this information will be used and recorded by Westlands.

If you **DO** want to receive telephone messages, please tick this box here ☐

If you **DO** want to receive text messages. please tick this box here ☐

If you **DO** want to receive emails, please tick this box here ☐

Summary Care Record

This is a computer based record. This contains some of your GP record e.g. current medications, allergies. It can be viewed immediately by appropriate staff providing care or support to you throughout Hampshire health care settings. For example in an emergency - A&Es, Ambulance Services, as well as other GP surgeries and out of hours providers.
You can opt to have additional information added to your Summary Care record such as significant medical history, anticipatory care information, immunisation and end of life care information.

If you **DO NOT** wish to have a summary care record then your records cannot be accessed outside of GP hours. This may mean that NHS Healthcare staff caring for you in the event of an emergency may not be aware of your current medication / allergies / conditions to treat you safely.

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

To be enrolled onto the Summary Care Record, you must give us your explicit consent

If you **DO** want to share your information using the Summary Care Record, please tick this box here ☐

If you **DO** want to share your information using the Additional Summary Care Record, please tick this box here ☐

Hampshire Health Record

This is a computer based record. This contains your entire GP record e.g. diagnosis, medications, test result. It does not include at the moment your consultation discussions. It can be viewed by appropriate staff providing care or support to you throughout Hampshire health care settings. For example in A&Es, Ambulance Services, and other GP surgeries and out of hours providers.

To be enrolled onto the Hampshire Care Record, you must give us your explicit consent

If you **DO** want to share my GP record onto the Hampshire Health Record, please tick this box here ☐

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NEXT OF KIN NOMINATION

YOUR NEXT OF KIN

Name:	
Relationship to you:	
Telephone:	

You may nominate anyone as your next of kin – spouse, partner, family member or friend, but you should know that in the absence of such a nomination, no-one can claim to be your next of kin.

It is sometimes very useful to the doctors and nurses caring for you to have the insight about how your health is from your next of kin, however, the staff can only do this if you give us your express permission to do so.

Please sign and date the box below if you want to give your next of kin this permission

Signed (Patient)		Date	

Regardless of who you nominate as your next of kin, they have no automatic right to view your medical record either in the surgery or online.

CARERS

ARE YOU A CARER? Yes ☐ No ☐

(*do you look after someone who is dependent on you some, or all of the time?*)

*** * *** If you answered YES to this question, please request a Carers Form when you hand in this completed form*** * ***

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NEW PATIENT QUESTIONNAIRE - ADULT

YOUR PERSONAL CIRCUMSTANCES:

Do you have significant mobility issues?			**Yes** ☐	**No** ☐
Housebound	☐	Wheelchair user		☐
Very poor mobility	☐			

Are you blind/partially sighted?	**Yes** ☐	**No** ☐
Do you have significant problems with your hearing?	**Yes** ☐	**No** ☐

Have you set up a lasting Power of Attorney for Health & Welfare? ***If so, please bring a copy into the practice with contact details for those who will assume responsibility for you.***	**Yes** ☐	**No** ☐
If so, please give details of those who will assume responsibility for you		

Have you made an advance directive/decision in place about any future care you do not wish to receive?	**Yes** ☐	**No** ☐
If so, are you satisfied that your wishes remain unchanged? ***Please bring a copy into the practice.***	**Yes** ☐	**No** ☐
Have you made a 'Do Not Attempt Resuscitation' order? ('Lilac Form') ***Please bring a copy into the practice.***	**Yes** ☐	**No** ☐
If so, are you satisfied that your wishes remain unchanged?	**Yes** ☐	**No** ☐

Height/Weight

What is your height? ______________________ What is your weight? ______________________

Smoking Status

Never smoked ☐ Current smoker ☐

Ex-smoker ☐ How many per day (average)?

Date stopped smoking Month: Year:

Have you considered giving up smoking? Westlands holds a stop smoking clinic. If you would like to talk to a nurse about this, please tick here and we will be pleased to make contact with you. ☐

ALCOHOL SCREENING

The set of questions on the next page give you and us an indication as to whether you are drinking more than is healthy.

Look at the **Alcohol screening Part 1** questions carefully, select the answer which most applies to you and put the column number of your answer in the '**Your score'** box.

If **all three** scores add up to **5 or more** complete the **Alcohol screening Part 2** section that follows. If in doubt, ask a receptionist who will be happy to assist.

Alcohol screening Part 1

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
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 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	

REMEMBER: If your score is **5** or more, complete the **Alcohol screening part 2** section below.

Alcohol screening Part 2

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	

Add up your scores from both Alcohol screening parts 1 and 2 then write the total in the 'TOTAL' box oppostite.

TOTAL

If you would like to talk to a nurse about your drinking, please tick here and we will be pleased to make contact with you. ☐

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ALLERGIES

Please list any drugs or substances (e.g. nuts, eggs) that you are allergic to (i.e. develops rash/swelling/anaphylactic shock – not side effects such as diarrhoea or nausea).

____

____

____

____

____

MEDICATIONS

Please provide a list of repeat medications:

1.
2.
3.
4.
5.
6.

*** Before these can be prescribed, you will need a review with one of our GP's. ***

FAMILY HISTORY

Please indicate if any of the following problems have affected a close blood relative (parent, sibling or child only):

Condition	
Heart disease (heart attack/angina)	☐
High cholesterol	☐
DVT or pulmonary embolism	☐
Hip fracture (parent)	☐
Cancer (please specify which type and approximate age of the affected relative)	

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HEALTH - Have you ever been diagnosed with:

Cancer

Type:		Year (approx.)	
Are you receiving treatment?		**Yes** ☐	**No** ☐

Heart or Circulatory Problems

High blood pressure	☐	Peripheral vascular disease	☐
Aortic aneurysm (AAA)	☐	Angina/heart attack	☐
Blood clots (DVT/PE)	☐	Stroke/TIA (mini-stroke)	☐
Atrial fibrillation (AF)	☐	Do you have a pacemaker/implanted defibrillator?	☐

Lung or Respiratory Problems

Asthma	☐	COPD/Emphysema	☐
Tuberculosis	☐		☐

Gastro-Intestinal Problems (Stomach & Gut)

Ulcerative colitis/Crohn's disease	☐	Hiatus hernia	☐
Liver function problems	☐	Stomach/duodenal ulcer	☐
Irritable bowel syndrome	☐	Severe indigestion	☐

Genito-Urinary Problems

Recurrent urinary Infections	☐	Kidney function problems	☐
Prostate problems	☐	Erectile dysfunction/problems	☐
Incontinence	☐	Abnormal smears	☐

Epilepsy

Do you have Epilepsy?		**Yes** ☐	**No** ☐
When did you last have a fit, approximately?		Please tick if you have been fit free for over 12 months.	☐
Roughly how often do you have fits?			☐

Diabetes - Which of the following are used to control your diabetes?

Diet alone	☐	Tablets	☐
Insulin	☐	Other injections	☐

Bone & Joint Problems

Hip replacement	Left ☐	Right ☐	Both ☐
Knee replacement	Left ☐	Right ☐	Both ☐
Other joint replacement (please state)			
Rheumatoid arthritis	☐	Osteoporosis (proven)	☐
Gout	☐		

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HEALTH - Have you ever been diagnosed with:

Mental Health Problems

Depression	☐	Personality disorder	☐
Dementia	☐	Anxiety	☐
Schizophrenia	☐	Cognitive impairment	☐
Bipolar disorder	☐	Other psychotic illness	☐
Self harm/suicide attempt	☐		

Skin problems

Eczema	☐	Psoriasis	☐
Ulcers	☐		☐

Other conditions	☐		☐
Overactive thyroid	☐	Underactive thyroid	☐
Migraine (with aura e.g. weakness visual disturbance, numbness)	☐	Any other significant medical problems not listed, or operations. Ask the receptionist for a separate sheet if required.	☐

For women

Please tick if you use any of the following contraceptive methods			
Combined pill	☐	Mini-Pill or Cerazette	☐
Depo-Provera Injections	☐	Copper Coil	☐
Implant in arm	☐	Mirena coil	☐
Date of Last Cervical Smear	☐		

Signature: **Date:**
(patient)