**New Patient Registration: For OVER 16s ONLY**

We need some information about you as soon as you register as your medical records can take several weeks to arrive. Please complete all the questions below.

*The Practice is required to process patient’s personal and special category data in various situations. Detailed information on how and why we do this can be found at* [*www.westtimperleymedicalcentre.co.uk*](http://www.westtimperleymedicalcentre.co.uk)*.*

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forenames |  |
| Any Previous Surnames |  | Date of Birth |  |
| NHS number  (if known) |  | Employment Status |  |
| Landline Number |  | Mobile Number |  |
| Email |  | | |
| Do you consent to being contacted via text? | | Yes No | |
| Do you consent to being contacted via email? | | Yes No | |

|  |  |
| --- | --- |
| Do you want to set up Online Access? | Yes No |
| *Please complete the ONLINE ACCESS (adults only) form included in the Patient Pack.*  **Each adult will need their OWN unique email address***. A pin document will be emailed to you and you must log onto* [*www.patientaccess.com*](http://www.patientaccess.com) *to complete the registration. This can only be completed if you provide an email address.* If you would like proxy access to act on the behalf of a child up to age 11 please request a proxy access form from reception.  *Children aged between 11 and 16 can only have proxy access if the clinician assess capacity.* | |

**Please note it is your responsibility to ensure we have up to date contact details on your records.**

|  |  |
| --- | --- |
| First language (if not English) |  |
| Do you require an Interpreter for consultations? | Yes No |
| Do you have any communication needs? | Yes No |
| If yes please explain |  |
| Do you have a carer? | Yes No |
| If yes please give their name, relationship and contact details |  |
| Are you a carer? | If so, for who |
| Are you permanently housebound? | Yes No |
| Are you a HM Forces Veteran? | Yes No |
| Do you consider yourself to have a disability? | Please specify |

Which if the following best describes how you think of yourself?

|  |  |  |  |
| --- | --- | --- | --- |
|  | White |  | Black Caribbean |
|  | White British |  | Black African |
|  | White Irish |  | Other Black Background |
|  | Indian |  | Chinese |
|  | Pakistani |  | Other Asian Background |
|  | Bangladeshi |  | Other Ethnic Group |
| If other please list | |  | |
|  | **Do not want to state ethnicity** |  | |

Which of the following best describes how you think of yourself?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Male (including trans male) |  | Female (including trans women) |
|  | Non-binary |  | In another way (please state): |

**Is your gender identity the same as the gender you were given at birth?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Which of the following best describes how you think of yourself?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Heterosexual or Straight |  | Gay or Lesbian |
|  | Bisexual |  | In another way (please state): |

**YOUR** Family History

*If any of your immediate family were diagnosed with any of these illnesses please tick the correct box*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mother | Father | Siblings |
| Asthma |  |  |  |
| Diabetes |  |  |  |
| Stroke/TIA |  |  |  |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |

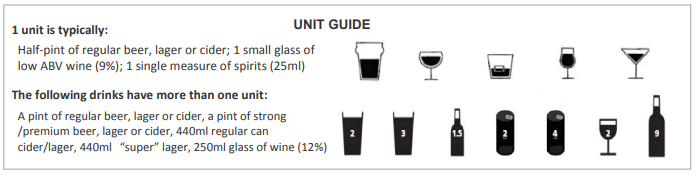
**YOUR** Health

|  |  |  |  |
| --- | --- | --- | --- |
| Do you suffer from any allergies or have you had a reaction to any medication? | | | Yes No |
| If yes, please detail: | | | |
| **Have you ever suffered from?** | | | |
| Epilepsy | Yes No | Glaucoma | Yes No |
| Hypothyroidism | Yes No | High Blood Pressure | Yes No |
| Diabetes Type 1 | Yes No | Stroke/TIA | Yes No |
| Diabetes Type II | Yes No | Heart Disease | Yes No |
| Depression | Yes No | Mental Health | Yes No |
| Cancer | Yes No | COPD | Yes No |
| Asthma | Yes No |  | |
| Other Serious or Chronic Illnesses (please list) |  | | |

|  |  |
| --- | --- |
| Do you take any regular prescribed medication? | Yes No |
| *If yes please provide us with an up-to-date re-order slip from your old practice so we can review this.* | |

|  |  |  |
| --- | --- | --- |
| Smoking Status | Never smoked tobacco |  |
| Ex-Smoker |  |
| Current Smoker |  |
| Current smokers how many do you smoke a day? |  | |

|  |  |
| --- | --- |
| Date of last Smear |  |
| Which city was this smear taken |  |
| Result |  |
| If you are using contraception – what do you use? |  |

**Alcohol Screening**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 a month | | 2-3 times a week | | 4 + times a week | |  |
| How many standard drinks containing alcohol do you have on a typical day when drinking? | 1 or 2 | | 3 or 4 | | 5 or 6 | | 7 to 9 | | 10+ | |  |
| How often do you have six or more drinks on one occasion? | Never | | Less than monthly | | Monthly | | Weekly | | Daily almost daily | |  |
| **If score 5+ then answer next 7 questions TOTAL** | | | | | | | | | | |  |
| During the past year, how often 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 |  |
| During the past year, how often have you failed to do what was normally expected of you because of drinking? | | Never | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |  |
| During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session? | | Never | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |  |
| During the past year, how often have you had a feeling of guilt or remorse after drinking? | | Never | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |  |
| During the past 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 someone else been injured as a result of your drinking? | | No | | Yes, but not in the past year | | | | Yes, during the past year | | |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down? | | No | | Yes, but not in the past year | | | | Yes, during the past year | | |  |

**Please Note:**

The law around organ donation [in England](https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/) has changed. All adults in England are now considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups. Please visit <https://www.organdonation.nhs.uk/> for more information.

# Application for online access to my medical record

|  |  |
| --- | --- |
| Name |  |
| Email Address |  |

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

|  |  |
| --- | --- |
| 1. Booking appointments | ❑ |
| 1. Requesting repeat prescriptions | ❑ |
| 1. Medical record access | ❑ |

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

*Please go to* [*www.westtimperleymedicalcentre.co.uk*](http://www.westtimperleymedicalcentre.co.uk) *to find the patient information leaflet about online access*

|  |  |  |
| --- | --- | --- |
| 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 | | ❑ |
| Signature: | Date: | |

*Please note, in your records there may be historic coding. This will be entered with a default date of 01.01. XX with the year of event being correct.*

*Screening results may take a while to be added to your online account.*

### For practice use only

|  |  |
| --- | --- |
| Identity Verified By |  |
| Date |  |
| What ID has been seen? |  |
| Proof of Address seen |  |

|  |  |  |
| --- | --- | --- |
| Authorised by: | | Date |
| Level of record access enabled  Contractual minimum 🗹  Other: ……………………………….… | Notes / explanation | |

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. 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 a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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 and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

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: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to the practice.