Roseworth Surgery

Dear Patient,

Welcome to Roseworth Surgery. We would like to provide you with a high standard of care whilst you are registered with us.

- Attached you will find a practice booklet and a new patient questionnaire. The practice booklet provides you with all the information you need to know about the practice and the services we offer including opening times and the procedure for ordering repeat prescriptions.

- You MUST complete the attached questionnaire. This information is vital and will provide us with the necessary knowledge to plan your health care appropriately prior to receiving your patient records from your previous practice (if this applies).

- If you are currently taking any medication, please provide us with a list of these from your previous GP.

- Please inform us if you are living with or moving to an address with someone who is already registered with us.

- You must provide proof of validity such as a passport, driving license, previous medical card etc. We will be unable to process your registration further until these are provided.

- If you need an interpreter please let us know as quickly as possible.

- The practice is participating in Summary Care Record. If you choose to have a summary care record you do not need to do anything, this will happen automatically. If you choose not to have a summary care record then you need to let us know by filling in an opt-out form which you can collect from reception.

The reception team is there to help you if you wish to clarify anything about the service we offer, please ask.

Yours sincerely

C Ramsey (Practice Manager)
13th May 2015

STAFF TO COMPLETE

Roseworth Surgery

Before handing the registration forms in, please check the list below to ensure you bring in everything we need to register you.

1. Is the whole form fully completed? ☐

2. Are you on medication? ☐
   - If yes, we will need you to provide a list of these from your previous GP.
   - EPS (Electronic Prescribing System)? This is for our patients who are on medication, this saves you coming to the Surgery to collect your Prescription and instead just going to your local Chemist to collect your medication. If you'd like this service, please let us know which Chemist you would like to use:

     _____

3. Do you want to be registered for Systemone online? ☐
   This is an online service we offer to our patients which gives them the oppertunity to order their medication, book/cancel appointments and ask questions online.

   If patient would like access to system on line, please inform patient that we will send password via Email, Sms Messaging or Letter. If patient would like access to detailed coded data they will be able to apply for for this online once they have received their password

4. Is the alcohol screening form completed? ☐

5. Do you have proof of your validity (passport / driving license) to bring and also proof of your home address? ☐

6. Do you need to see a Doctor or a Nurse urgently? ☐

7. Have you just recently moved into the area? Yes No

8. Has patient signed GMS1 YES

For admin use only
Date form completed: _ _ / _ _ / _ _ _ _ Name: _____

ROSEWORTH SURGERY NEW PATIENT QUESTIONNAIRE

ID SEEN ……

Today's Date:	**Date of Birth:**	Mr / Mrs / Miss / Ms / Other	Male / Female
Surname (Family Name):		**First Name(s):**	
Home Tel Number: **Mobile Tel Number:** **Do you consent to SMS texting? Yes/No** **Email Address:** **How would you prefer to be contacted?** **SMS texting/email/telephone/letter/fax**		**Address:** **Postcode:** **How long have you lived here ……** **Previous address:** **Postcode:** **How long hve you lived here ……**	
Place of Birth:	**Do you have a Carer?** Yes / No Name of person who cares for you: Contact number for your carer:	**Are you a Carer?** Yes / No Person you care for: If yes please ask at Reception for Carers pack.	
Relationship Status:			
Employment Status:	**Occupation:**	**Are you a Military Veteran?** Yes / No	**YOUR NHS NUMBER IS……**

Ethnicity:-

White British/Other White White Irish Asian/Other Bangladesh Black Caribbean

Black African British Mixed Chinese Other Black Other Mixed

Do not wish to disclose

Are you happy to have a Summary Care Record? Yes / No **Would you like access to Online Services** Yes/No		**Next of Kin Details:** **Relationship:** **Name:** **Address:**
Do you require an Interpreter, British Sign Language Interpreter or Advocate? Yes / No		
Main Language: **Other Languages Spoken:**	**What is your religion?**	**Contact Number:**

Please detail any special needs that you have (eg disability, Information in Braille, Large Print, Easy Read. We can support you to Lip Read or use a Hearing Aid or Communication Tool etc.):

Have you, or are you suffering from any of the following? (please circle)

Stroke / Heart Attack / Blood Pressure / Diabetes / Depression / Cancer / Epilepsy / Asthma / Angina / Thyroid Problems / Lung Disease / Emphysema / Mental Health Problems

Are you under the care of any hospital specialist at present? Yes / No

Please detail if yes:

Have you had any serious illness, accidents or operations: Yes / No

Please detail if yes:

Please bring any **regular** medications you are taking (either on prescription or bought over the counter)
Please bring all boxes/bottles/packets of your medication to your appointment

Name of Medicine	Strength & how often taken	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you want your prescriptions to go EPS (Electronic Prescribing System) to your local pharmacy? This is for our patients who are on medication, this saves you coming to the Surgery to collect your Prescriptions and instead, just going to your local Chemist to collect it.

If you'd like this service, please let us know which Chemist you'd like to use:

_____

Please detail any allergies that you suffer from:

What is you BP reading? (we have machine in waiting room)

What is your Height?

What is your Weight?

Would you be interested in joining our Patient Forum Group? Yes/No

Would you be interested in receiving our News Letter? Yes/No

If a close relative (parent/brother/sister) has had any of the following please let us know which relative and how old they were when it happened:

Stroke:	Yes / No	Relationship:	Age:
Heart Attack:	Yes / No	Relationship:	Age:
Breast Cancer:	Yes / No	Relationship:	Age:
Diabetes:	Yes / No	Relationship:	Age:
Bowel Cancer:	Yes / No	Relationship:	Age:
Asthma / COPD	Yes / No	Relationship:	Age:

Do you smoke? Yes / No / Ex Smoker / Have never smoked tobacco

If yes, how many cigarettes do you smoke a day? .....

If yes, would you like advice/help to stop? Yes/No

If ex smoker, when did you give up?

Which word best described you level of activity? Inactive / Gentle / Moderate / Vigorous

What immunisations have you had?

For Women Only:

How many pregnancies have you had? _____

Have you ever had problems in pregnancy? Yes / No

If yes please detail: _____

_____

Are you currently using birth control? Yes / No

If yes please select: Pill / Injection / Coil / Implant / Other _____

When was your last smear test? _____

FOR OFFICE USE ONLY:

Forms of ID _____

Photographic ID _____

Is the patient a visitor from overseas? Yes / No

If YES, for how long? _____

To be completed at new patient appointment

Height _____ Weight _____ BP_____

Thank you for taking the time to complete this questionnaire.