Under 16s

Roseworth surgery

We need you to:

1. Complete the purple form (GMS1).
2. Completed the New Patient Questionnaire.
3. Any Medication you are currently taking (including any boxes).
4. Proof of your validity (passport, ARC card, letter from Home Office etc).
5. Any immunisation records.- see immunization record form

Failure to attend your appointment on time or to bring all of the above could result in your registration being delayed or declined.

Further details of the above are included in the letter in this pack.

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 questionairre. 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 <u>MUST</u> complete the attached health questionnaire and bring it to your appointment.. 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).

- In this pack is a urine sample bottle. Please bring this to your appointment.

- If you are currently taking any medication, please bring them with you to your appointment.

- 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 licence, 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.

- Please remember this appointment is for you only. If you also wish another member of your family to be registered please contact our Reception Staff.

- 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 are there to help you if you wish to clarify anything about the service we offer, please ask.

Yours sincerely,

C Ramsey (Practice manager)
01.12.2013

Under 16's

ROSEWORTH SURGERY
NEW PATIENT QUESTIONNAIRE

Welcome to Roseworth surgery. We would be grateful if you could spend a few minutes answering the following questions. It will give the doctors and nurses important information about your child's medical history and will help us to provide a better service.
You must complete this form and bring it to your child's new patient appointment along with the purple GMS1 form or medical card.

Today's Date: | **Date of Birth:** | **Boy / Girl:**

Surname (Family Name): | **First Name(s):**

Address:

Postcode:

Home Tel Number:
Mobile Number:
Do you consent to SMS texting Yes/No
How would you prefer to be contacted?
SMS Texting/Email/Telephone/Letter/ Fax
E-mail:

Ethnicity:-

British/Mixed	White / Asian	Other Asian	Irish	Other Mixed
Caribbean	Other White	Indian / British	African	W&B Caribbean
British / Pakistan	Other Black	W&B African	British / Bangladeshi	Chinese
Do not wish to disclose				

Parent or Guardian Details:-
Name(s): **Contact Tel Number:**
Address: **Mobile Number:**
E-mail:

Place of Birth: | **Main Language Spoken:** | **Religion:**

Were there any problems at birth? Yes / No if yes please detail:

Has your child had any serious illness, accidents or operations? Yes / No
If yes please detail:
Are you happy for your child to have Summary Care Record? Yes/No
Are you happy to use the Electronic prescribing Service for medication Yes/No
How would you prefer to be contacted email/sms texting/telephone/letter
If child is 14 + would they be interested in joining our patient forum group? Yes/No

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	Dose / Strength	How may times a day
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Please detail any allergies that your child suffers from:

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:

Stoke:	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:

Other serious illness in the family?

Please detail:

Has your child had a hearing test (aged about 7-9 months)? Yes / No

Has your child had an eye test (aged about 3 years)? Yes / No

Do you think your child has had all his/her immunisations? Yes / No

Please provide your child's immunisation book or complete immunization record form.

Do you have any worries about your child's health? Yes / No

If yes please detail:

Which school does your child attend:

____

Does your child have any social care involvement? YES/NO

If yes please state who is involved:

Will your child require an interpreter? Yes / No

For Teenagers Only

Which word best describes your level of activity? Inactive / Gentle / Moderate / Vigorous

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

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

If ex smoker, when did you give up?

Do you drink alcohol: Yes / No If you answered yes, please complete the following:

Questions	**0**	**1**	**2**	**3**	**4**	
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 standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

FOR OFFICE USE ONLY:

Forms of ID ________________________________ Is the patient a visitor from overseas? Yes / No

Photographic ID _____________________________ If YES, for how long? _______________________

Thank you for taking the time to complete this questionnaire.