Hastings & Rother Healthcare
New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Please bring a Passport/Driving Licence to confirm your date of birth and address.

Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**	
Mr / Mrs / Miss / Ms / Other……..					**Work Number**	
Address and Postcode					**Mobile Number:**	
					E-mail Address:	
					Next of Kin:	
					Next of Kin Contact Number:	
Date of Birth:		**Previous / Mother's surname if different:**			**Town & Country of Birth**	
Marital Status:		**Gender:**	**Male:**	**Female:**	**Other residents of your home:**	
Occupation:						
Names & Ages of Children						
Housing (Select one)	**House**	**Maisonette**	**Flat**	**Mobile Home**	**NHS Number (If Known)**	
Previous Address					**Previous Postcode:**	
					Previous Doctor Telephone No.	
Previous Doctor Name & Address:					**Previous data released?**	**Yes** / **No**
					If applicable, date you first came to live in Britain:	
If returning from Armed Forces:		**Your Service or Personnel Number**			**Your Enlistment Date**	
Your height:	**Feet / inches**	**cm**		**Your weight:**	**Stones / lbs.**	**kg**
Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**		**Buddhist** / **Hindu** / **Muslim**	
	Sikh	**Jewish**	**Jehovah's Witness**		**No religion**	**Other religion (state)**

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	No. times per week		Type(s) of exercise:		

Your Medical Background:		
What illnesses have you had & when?		
What operations have you had and when?		
Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**	
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**
	Thyroid Disorder		**Any other important Family Illness?**		

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Specific Needs: **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:**	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Signed:** **Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**

Women only:

When was your last smear taken?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

<u>Summary Care Records.</u>

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

<u>Patient Participation Group</u>

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest in joining, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and keep you up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (If interested, tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing.
The Consultation will also establish relevant past medical and family history, including:
- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: ***www.hastingsoldtownsurgery.co.uk www.warriorsquaresurgery.co.uk www.churchwood-surgery.co.uk/***

ALCOHOL QUESTIONNAIRE

PLEASE CIRCLE THE ANSWER THAT IS CORRECT FOR YOU

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?

Never (0) **Monthly or less (1)** **Two to four times a month (2)**

Two to three times per week (3) **Four or more times a week (4)**

HOW MANY DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING?

1 or 2 (0) **3 or 4 (1)** **5 or 6 (2)** **7 to 9 (3)** **10 or more (4)**

HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION?

Never (0) **Less than monthly (1)** **Monthly (2)**

Two to three times per week (3) **Four or more times a week (4)**

YOUR NEXT OF KIN

NAME : ……

RELATIONSHIP: ……

TEL NUMBER : ……..

IF IT'S NECESSARY, IS IT OK TO DISCUSS YOUR HEALTH WITH YOUR NEXT OF KIN?

YES **NO**

IS YOUR NEXT OF KIN YOUR EMERGENCY CONTACT?

YES **NO**

IF NO – WHO SHOULD WE CONTACT IN AN EMERGENCY?

NAME : ……..

RELATIONSHIP: ……

TEL NUMBER : ……..

DUE TO RENEWED GOVERNMENT GUIDELINES WHEN REGISTERING NEW PATIENTS GP'S ARE REQUIRED TO ASK IF YOU OR SOMEONE CONNECTED TO YOU IS CLASSED AS A VULNERABLE PERSON, THEREFORE WE WOULD BE MOST GRATEFUL IF YOU COULD ANSWER THE FOLLOWING 2 QUESTIONS –

1) DO YOU CURRENTLY LIVE WITH SOMEBODY WHO IS CLASSED AS A VULNERABLE ADULT/CHILD? (Please circle)

YES NO

If yes, who is this person to you? …….

2) DO YOU HAVE ANY FAMILY MEMBERS CLASSED AS VULNERABLE?

YES NO

If yes, please specify …….

Signed ……

All information provided in your answers is strictly confidential and will not be passed onto any other party.

TEXT MESSAGES

Would you like to opt in to our SMS service?

This includes receiving text messages for:

- Booked appointment reminders
- Appointment invites to clinics i.e. blood tests, blood pressures, immunisations etc.
-

Note: This is a non-reply messaging service.

Would you like to opt in? **YES** **NO**

MOBILE NO:……

NAME:……

SIGNED:…….

DATE:……..

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.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **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.

c) **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.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

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 your GP practice.

Terms & Conditions for using Online Services

About Patient Access

Patient Access is only available to patients who are registered with our surgery.

Using Patient Access, you can now view, book and cancel appointments at Roebuck Surgery and request repeat medication prescriptions from home, work or on the move - wherever you can connect to the internet. What's more, because Patient Access is a 24 hour online service - you can do this in your own time, day or night.

Confidentiality and Security

Information sent via Patient Access is encrypted. This means that messages sent cannot be intercepted or read by others, and only the Patient and the Practice are able to see any personal information.

The computer system is connected to Patient Access through the NHS network, which is more secure than a normal internet connection. The Surgery will only enable the internet access facilities if requested to do so by the Patient.

Terms and Conditions

Whilst the Surgery makes all reasonable efforts to provide the Service, it is not liable for any failure to provide the Service, in part or full, for any cause that is beyond its' reasonable control.

This includes, in particular, any suspension of the Service resulting from maintenance and upgrades to the systems or those of any party used to provide the Service.

You must keep your Personal Details secret and take all reasonable precautions to prevent the fraudulent use of your Personal Details. If fraudulent use is suspected, contact the Surgery as soon as possible.

a) This facility is currently available for ROUTINE doctors' appointments only, to discuss a single issue.
b) The system is set to allow three appointments to be booked online at any one time.
c) All booked appointments are cancellable on-line; if an appointment booked on-line, is not cancelled without good reason, and results in a 'did not attend', the Surgery reserves the right to revoke its use and remove the patients from our list.
d) If your selected GP becomes unavailable at short notice we may move your appointment to another GP without notification.
e) If the appointment can not be found on our system we will only honour the appointment if you have printed the confirmation of booking
f) Requests for repeat medication prescriptions will take 2 working days to process.

☐ If you would like access to your basic medical record which includes medications, allergies and immunisations then please tick the box.

Hastings & Rother Healthcare reserves the right to change the Service from time to time and shall give appropriate notice of any material changes. They may, where considered appropriate for patient protection, suspend, withdraw or restrict the use of the Service or any part of the Service. Patients will be notified as soon as practicable if any such action is taken. The surgery reserves the right to vary these Terms and Conditions and appropriate notice will be given of any material changes.

Patient Name:……

Signed:…….. Date:……

PATIENTS AGREEMENT

On joining Hastings & Rother Healthcare please be prepared to see a Nurse instead of a Doctor for minor illnesses or when appropriate. Our Nurses are skilled and an essential part of our patient care team.

We also ask patients to agree not to be abusive to staff. We have a zero tolerance policy and will remove any such patients from our list.

It is the patient's responsibility to notify us of any change of details, ie, name, address and telephone number so we can update your records.

Patients who regularly fail to attend appointments without cancelling may be removed from our Practice list.

Print name ……

Signature …….

Date ……

FOR OFFICIAL USE ONLY: To be completed by Nurse.

BLOOD PRESSURE: ……

PULSE: ……..

WEIGHT: ……..

HEIGHT: ……..

WAIST CIRCUMFERENCE: ……..

SMOKING CESSATION GIVEN IF APPLICABLE? ……..

READY TO STOP SMOKING? ☐ NOT INTERESTED IN STOPPING?

LARC INFO DISCUSSED IF APPLICABLE? ……

BLOOD SAMPLE TAKEN: ☐

HIV SCREENING CONSENT: ☐ DECLINED: ☐

HIV BLOOD TEST TAKEN: YES: ☐ NO: ☐

PHARMACY EPS NOMINATION: Other:_____

ANDERSENS: ☐ BLOOMS: ☐ BOOTS PRIORY MEADOW: ☐

BOOTS LONDON ROAD: ☐ BOOTS RAVENSIDE: ☐ CLARITY: ☐

DAY LEWIS HIRST: ☐ DAY LEWIS PORTERS: ☐ KAMSONS: ☐ LAYCOCKS: ☐

LAYCOCKS LITTLE RIDGE: ☐ LLOYDS HIGH STREET: ☐ LLOYDS SILVERHILL: ☐

LLOYDS BATTLE ROAD: ☐ MORRISONS: ☐ OSBORN PHARMACY: ☐

SAINSBURYS: ☐ STATION PLAZA: ☐ TESCO: ☐ WEST ST LEONARDS: ☐