

**Welcome to Beechwood Surgery**

**1: Reception checklist: Patients 16 Years & Over**

1. **Do not accept incomplete registrations;** if incomplete return the registration documents to patient and ask to return with all required elements.

* Please check NHS number, DOB, Address (both past and present)
* Previous surname if the patient has the title of MRS
* Date of Entry to UK if coming from abroad
* Telephone contact numbers (mobile number preferred)
* Place of birth (TOWN not hospital)
* Has the patient signed the Purple GMS1 form?

1. ID checked – if available

(Photo ID – Driving Licence or Passport. Proof of address – Utility Bill or Bank Statement within 3 months)

1. Nominate a pharmacy (page 6)

1. Opt out of the Summary Care Record scheme - please add (page 10)
2. Alcohol screening form – please add (page 7)

**HAVE ALL SECTIONS A – E HAVE BEEN COMPLETED?**

Form completed by (please print name)………………………………………..

**2: Reception Once this form has been checked please leave in the registration tray**

**3: Admin to register patient, code as required, book Health check for patients aged 40-74 and then pass to Duty GP**

|  |  |
| --- | --- |
| **4:Duty Doctor Use Only – Please tick the box to indicate which action needs to be taken and pass back to Reception to action as requested below:** | |
| **GP appointment required: Yes No**  State reason for appointment:  ………………………………………. | **Nurse Appointment Yes No**  State reason for appointment:  ………………………………………. |
| **Pharmacist Appointment Yes No**  State reason for appointment:  ………………………………………. | **No Action Required**  Scan to record |
| **Mental Health Practitioner Yes No** |

**Reminders:**

* Age 40-74 – Healthcheck booked by Admin
* Repeat Pill only – Nurse appointment
* Asthma / Diabetic – Asthma ML / JS, Diabetic MD / VK Nurse appointment
* Repeat meds – Pharmacist SH / JS
* Mental Health – GP appointment
* General concerns – GP appointment at Duty discretion

**Beechwood Surgery**

**Pastoral Way, Warley, Brentwood, CM14 5WF**

**Tel: 01277 212820**

**www.beechwood-surgery.co.uk**

**1.) BACKGROUND DETAILS**

**CONTACT DETAILS - *\* It is your responsibility to keep us updated with any changes to your contact details***

|  |  |
| --- | --- |
| First name |  |
| Surname |  |
| Former surname |  |
| Address | Post code: |
| Date of birth |  |
| Male or Female | Have you ever identified as a different sex? Y N |
| Mobile number | Text message consent: Y N This will be used to confirm appointments and other important communications. |
| Home contact number | Home answerphone message consent: Y N |
| Email address | Email contact consent: Y N |
| Country/Town of Birth |  |
| Family registered here? | Y N |
| Next of Kin | Name: Telephone: Relationship to you: |

**ETHNIC GROUP (please tick):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| White(British) |  | Black British |  | Asian British |  | Pakistani |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| White(Irish) |  | Black Caribbean |  | Bangladeshi |  | Chinese |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| White(other) |  | Black African |  | Indian |  | Other |  |  |

Please state …………………………………………………..

**COMMUNICATION NEEDS**

|  |  |
| --- | --- |
| Language | What is your main spoken language? .................................................................. |
| Do you need an interpreter? Yes No |
| Communication | Do you have any communication needs? (If **YES** please specify below) Yes No  Hearing aid Large print British Sign Language  Lip reading Braille Makaton Sign Language Guide dog |

**EMPLOYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Employed |  | Student |  |
| Self‑employed |  | Unemployed |  |

**Occupation (if applicable):………………………………………………………………………………….....**

**CARER DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are **YOU** a carer? | Yes – informal/unpaid carer Yes – occupational/paid carer | | | |
| Do you **HAVE** a carer? | Yes | Name\*: | Tel: | Relationship: |

\*Only add a carer’s details if they give their consent to have these details stored on your medical record

**2.) MEDICAL HISTORY**

**ILLNESSES – do you suffer from or have suffered from (please tick box)**

|  |  |  |
| --- | --- | --- |
| Medical condition |  | |
| Asthma |  | |
| COPD |  | |
| Epilepsy |  | |
| Thyroid | Under/overactive (please circle) |  |
| Diabetes/type | Type I or Type II (please circle) |  |
| Liver disease |  | |
| Heart disease |  | |
| Stroke/TIA | (Please also state type) | |
| High BP |  | |
| Cancer | (Please also state type) |  |
| Kidney disease |  | |
| Depression |  | |
| Peripheral Arterial Disease |  | |
| Heart Failue |  | |
| Inherited High Cholesterol |  | |
| Atrial Fbrillation |  | |

**FAMILY HISTORY**

Please tick any significant family history of close relatives with medical problems **and confirm which relative e.g. mother, father, brother, sister, grandparent**

|  |  |  |
| --- | --- | --- |
| Medical condition | Relative | |
| Asthma |  | |
| COPD |  | |
| Epilepsy |  | |
| Thyroid | Under/overactive (please circle) |  |
| Diabetes/type | Type I or Type II (please circle) |  |
| Liver disease |  | |
| Heart disease |  | |
| Stroke |  | |
| High BP |  | |
| Cancer | (Please also state type) |  |
| Kidney disease |  | |
| Depression |  | |

Other (please state below)

………………………………………………………………………………………………………………………………………………………………………….............

………………………………………………………………………………………………………………………………………………………………………….............

………………………………………………………………………………………………………………………………………………………………………….............

**ALLERGIES (please specify):**

|  |  |
| --- | --- |
| Please record any allergies or sensitivities below: | Symptoms: |

|  |
| --- |
| **PRESCRIPTIONS** Please name the pharmacy you would like to collect your prescriptions from: |
| Pharmacy: |

**CURRENT/REPEAT MEDICATION – Please provide a copy of your repeat prescription from your previous GP if possible.** Please state below including dose and frequency if known:

**3.) LIFESTYLE**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Alcohol: Please answer the following questions which are validated as screening tools for alcohol use.** | | | | | | | |
|  | | | | | | |
| **AUDIT–C 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 per month | 2-3 times per week | 4+ times per week |  | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  | |
| A score of **less than 5** indicates *lower risk drinking***.** | | | | | TOTAL: |  | |

**Scores of 5 or more requires the following 7 questions to be completed:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT QUESTIONS**  (after completing 3 AUDIT-C questions above) | **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 last year |  | Yes, during 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 last year |  | Yes, during last year |  |
|  | | | | | TOTAL: |  |

Alcohol units guide

**3.) LIFESTYLE (CONTINUED)**

|  |  |  |  |
| --- | --- | --- | --- |
| Height (cm) : |  | Weight (kg): |  |

**EXERCISE HABIT:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| None |  | Light |  | Moderate |  | Heavy |  | Regular |  | Please specify: |  |

|  |  |
| --- | --- |
| **SMOKING** | |
| Do you smoke? | Never smoked Ex-smoker Yes |
| How many cigarettes did/do you smoke each day? | Less than one 1-9 1 10-19 20-39 40+ |
| Would you like help to quit smoking? | Yes No  For further information, please see: [www.nhs.uk/smokefree](http://www.nhs.uk/smokefree),  or call Essex Lifestyle Service: 0300 303 9988 |

**THE PRACTICE DOES NOT OFFER A QUIT SMOKING PROGRAMME – PLEASE SEE ABOVE OF HELP IF IT’S REQUIRED.**

**If you would like a new patient health check please contact reception.**

|  |
| --- |
| **Students Only:** |
| Students are at risk of certain infections, including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression.  Please see www.nhs.uk/livewell/studenthealth |

**WOMEN ONLY:**

**Do you use any contraception? Yes No**

**If yes, please tick:** Barrier (condoms) Oral contraceptive pill Implant

Coil Injection

If needed, please book appointment

**Are you currently pregnant?** YES NO Unsure

**If Pregnant, what is your due date?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last cervical smear:**

**Have you ever had an abnormal smear result?** YES NO Details: Date:

**Number of pregnancies** (please include any miscarriages or terminations)

|  |
| --- |
| **Organ and Blood Donation** |
| To register your details on the NHS Organ Donor Register please go to: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk).  To register your details on the NHS Blood Donor Register please go to: [www.blood.co.uk](http://www.blood.co.uk) |

**BP READING:**

**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.

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.

**NEW PATIENT CHECKLIST (FOR PATIENTS TO COMPLETE):**

**Please tick all the boxes below to confirm you have completed and understood the requirements for new patients so that your registration can be completed successfully:**

|  |  |
| --- | --- |
|  | Completed and signed New Patient Questionnaire |
|  | Completed and signed GMS1 form |
|  | Photo proof of ID *(e.g. passport, photo driving license or photo ID card)* |
|  | Proof of address *(e.g. bank statement, utility bill or council tax from within the last three months)* |
|  | If you are on repeat medication please ensure you have at least 30 days of medication from your current surgery and ensure you make an appointment with a GP before you put in a new prescription request with us (please tick to confirm you understand this even if you do not have any repeat medication) |
|  | Completed Summary Care Record form |

|  |  |  |
| --- | --- | --- |
| **SIGNATURES** | | |
| I confirm that the information I have provided is true to the best of my knowledge. | | |
| **Signature** |  | Signed on behalf of patient |
| **Print name** |  | |
| **Date** |  | |

**4.) ONLINE ACCESS**

Please read information **overleaf** before completing this form.

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |

**YOUR HEALTH RECORD**

|  |
| --- |
| Do you consent to your GP practice sharing your health record with other organisations who care for you? |
| Yes *(recommended option)*  No *(not recommended, please discuss this with your GP before ticking this option)* |
| Do you consent to your GP practice viewing your health record from other organisations that care for you? |
| Yes (recommended option)  No |

**All new patients will be given access to the following services:**

1. Booking Appointments
2. Requesting repeat prescriptions
3. Access to my coded\* medical records

\*Contains any medical codes that have been recorded)

**Application for online access to my medical record**

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

1. I have read and understood the information on the leaflet attached to this form 
2. I will be responsible for the security of the information that I see or download 
3. If I choose to share my information with anyone else, this is at my own risk 
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
5. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible 

If you are registering children under 12 please tick that you would like to have access to their record at the same time as your own 

|  |  |  |  |
| --- | --- | --- | --- |
| Print name: |  | | |
| Signature: |  | Date: |  |

### For practice use only : Coded: Xabui / Registered for online access. XaeEr / Declined online access.

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏 Photo ID 🞏 | Name of verifier | Date |
| Name of person who authorised (if applicable) |  | | Date |

**ONLINE ACCESS**

Online access gives you the ability to view your medical record and test results, as well as order prescriptions and book appointments.

If you would like to apply for this now, please read the information overleaf and then sign the attached application form.

**Important Information – please read before signing attached form**

If you wish, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medication you take regularly and look at your medical record. You can still use the telephone to call in to the surgery to book appointments as well. It’s your choice.

**It will be your responsibility to keep your login details safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**

If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

**If you print out any information from your record, it is also your responsibility to keep it secure. If you are at all worried about keeping printed records safe, we recommend that you do not make copies at all.**

**Before you apply for online access to your record, there are some other things to consider.**

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details:

|  |
| --- |
| **Forgotten history**  There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news**  If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone**  It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion**  If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information**  Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery. |
| **Information about someone else**  If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

**More information**

For more information about keeping your healthcare record safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society: Keeping Your Online Health and Social Care Records Safe and Secure <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf>