Caritas Group Practice New Patient Registration

Additional Contact Information

Mobile or Work Telephone Number:……

Email Address: ……..

Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age? YES / NO

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for: ……...

their address ……..

In order that we may take into account a patient's culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices

White British	☐	Pakistani	☐
White Irish	☐	Bangladeshi	☐
White Other	☐	Other Asian background	☐
White & Black Caribbean	☐	Black Caribbean	☐
White & Black African	☐	Black African	☐
White & Asian	☐	Other Black background	☐
Other Mixed background	☐	Chinese	☐
Indian	☐	Any Other	☐

Additional Information

Height: Weight:

As a practice we offer new patient appointments, would you like to book one: Yes/No

Are you taking any regular medication? Please list: (use additional sheet if req'd)

Summary Care Record

(Please refer to additional information sheets)

☐ **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

☐ **Undecided -** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff within 12 weeks. If you do nothing, after this time, we will assume that you are happy with these changes and create a Summary Care Record for you.

☐ **No I do not want a Summary Care Record –** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.

Smoking status- Over 16 yrs

Current Smoker ☐

Current Non-Smoker ☐ → Date/Year Stopped Smoking ……

Never Smoked Tobacco ☐

Assistance During Appointments

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator ☐

Deafness – require a sign language translator ☐

Disability – require a carer ☐

Contraceptive Choice

In order that we can arrange the correct follow-up, please let us know if you are using either of the following contraceptive devices:-

IUCD (coil) ☐ Date of insertion……

Implanon/Nexplanon ☐ Date of insertion……

Gender

- ☐ Woman (including trans woman)
- ☐ Man (including trans man)
- ☐ Non-binary
- ☐ In another way

Note for non-binary patients: the GMS1 form cannot be altered, therefore if you are non-binary, please ask for information on screening services.

Do you consider yourself to be?

- ☐ Heterosexual or straight
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ I don't know/I'm not sure say
- ☐ Other (please specify)……

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

- ☐ Yes
- ☐ No

Trans patients may not be invited to routine screenings and can miss out on important health checks. Please ask a doctor or nurse to see if you're due a screening and book an appointment to discuss how we can make your screening most comfortable for you.

Women, Trans Men And Non-Binary People With A Cervix (Or Other People With A Cervix

Have you had a cervical smear? Yes/No

When was the last one? Date……

What was the result? …….

☐ Is the practice accessible to you?
☐ Are you on repeat medication?

Please provide your next of kin details:

Name: ……..

Contact No: ……

Relationship: …….

Confidentiality Statement

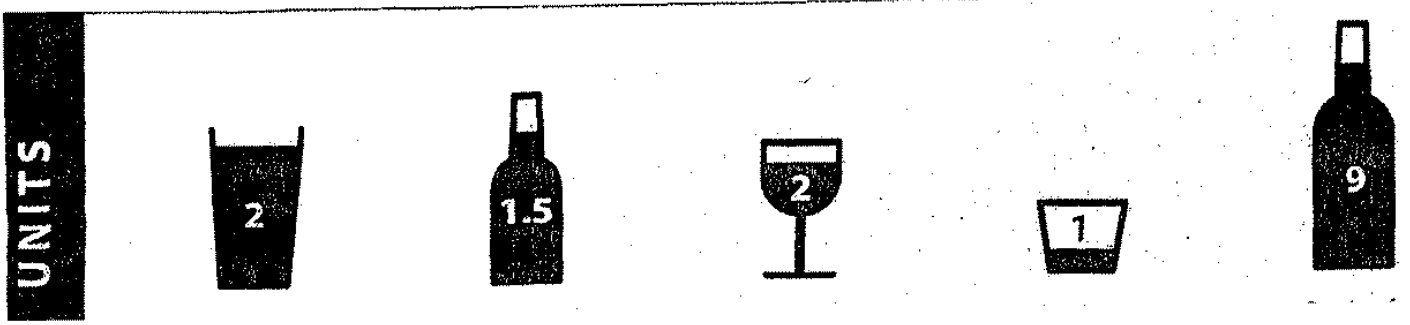
We hold your patient records in the strictest confidence, regardless of whether they are electronic or on paper. We take all reasonable precautions to prevent unauthorised access to your records, however they are stored. Any information that may identify you is only shared with the practice team, or, if you are referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone else if you give your permission in writing.

All patients can expect that their personal information will not be disclosed without their permission (except in the most exceptional circumstances when disclosure is required when a person is at grave risk of serious harm). Where disclosure of information is required which is non-routine in nature the patient will, where possible, be fully informed of the nature of the disclosure prior to this being released. Where the decision is made to disclose information, the decision to do so must be justified and documented. Person-identifiable information must not be used unless absolutely necessary – anonymised data should be used wherever possible.

AUDIT

Questions	0	1	2	3	4	Your Score
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 units of alcohol 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	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	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 last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL SCORE



IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this.

PROOF OF NAME
(One of the following)

Birth Certificate
Marriage Certificate
Driving Licence (valid)*
Passport (Valid)*

PROOF OF ADDRESS;MUST BE DATED WITHIN THE LAST 3 MONTHS
(One of the following)

Utility Bill
Council Rent Book
Bank Statement
Credit Card Statement
Letter from Benefits Agency

***Please note if applying for Online Access to your medical records, photo ID must be produced.**

Information for our patients.

We're improving how we communicate with patients. Please tell us if you need information in a different format or need communication support.

Out of area registration:

New arrangements introduced from January 2015 give people greater choice when choosing a GP practice. Patients may approach any GP practice, even if they live outside the practice area, to see if they will be accepted on to the patient list.

GP practices have always had the ability to accept patients who live outside their practice area. Regardless of distance from the practice, the practice would still provide a home visit if clinically necessary.

The new arrangements mean GP practices now have the option to register patients who live outside the practice area but without any obligation to provide home visits.
Out of area registration (with or without home visits) is voluntary for GP practices meaning patients may be refused because they live out of area.

If your application is considered the GP practice will only register you without home visits **if it is clinically appropriate and practical in your individual case**. To do this we may:

- Ask you or the practice you are currently registered with questions about your health to help decide whether to register you in this way

- Ask you questions about why it is practical for you to attend this practice (for example, how many days during the week you would normally be able to attend)

If accepted, you will attend the practice and receive the full range of services provided as normal at the surgery. If you have an urgent care need and the surgery cannot help you at home we may ask you to call NHS 111 and they will put you in touch with a local service (this may be a face to face appointment with a local healthcare professional or a home visit where necessary).

We may decide that it is not in your best interests or practical for you to be registered in this way. In these circumstances we may offer you registration with home visits, for example:- if you live just outside the practice area or we may not register you and advise you should seek to register (or remain registered) with a more local practice.

If accepted, but your health needs change, we may review your registration to see if it would be more appropriate for you to be registered with a GP practice closer to your home.

This new arrangement only applies to GP practices and patients who live in England. For further information visit the NHS Choices website (www.nhs.uk)

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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

1. I have read and understood the information leaflet provided by the practice	☐
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

FOR PRACTICE USE ONLY

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation

FOR PRACTICE USE ONLY

	Checked By (Initials)
Registration Form completed and signed	
Ethnicity completed	
Alcohol Screening Questions completed	
Smoking Status completed	
SCR option selected (Opt-Out Form completed if dissent given)	
ID Verified and photocopied	
New Patient Screening appt made	
Given Named GP letter	
Check if requesting online access and if so sign to say you have seen ID	