Littlewick Medical Centre

Erewash Health PARTNERSHIP

42 Nottingham Road, Ilkeston, Derbyshire DE7 5PR
Tel: 0115 932 5229 • Fax: 0115 932 5413
www.littlewickmedicalcentre.co.uk

New Patient Questionnaire:

To provide you with the best possible care, you **MUST** complete the GMS1 form and new patient questionnaire. This gives us details about you and your medical history whilst we wait for your medical records to be received from your previous doctor. Please complete a separate form for each member of your family or household.
All information is held in the strictest confidence.

Date: .....

Your Information

Name: ..... Date of Birth: .....

Address: ..... Postcode: ..... (Essential)

Tel no: ..... Mob no: .....

Would you be happy to receive text messages from the surgery as appointment reminders? YES / NO

Email address: ..... Marital status: .....

Under 18's – School attended: .....

Occupation: ..... Have you been registered here before? YES / NO

Next of Kin: ..... Relationship to patient: .....

Care Home: YES / NO – Nursing or Residential: .....

In which Country were you born: ..... Language Spoken: .....

Religion: ..... Interpreter Required? YES / NO

Ethnicity:						
White			**Black, or Black British**			
Please tick which one applies						
British	Irish	Other	Caribbean	African	Other	
Mixed			**Asian, or Asian British**			
White/Black Caribbean	White/Black African	Other	Bangladeshi	Pakistani	Indian	Other

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Medical History

Do you have a Family History of the following conditions:

Condition	Yes	No		Height
Hypertension			**All patients aged 40 and over will be offered an appointment with the Nurse or Healthcare Assistant for a NHS Heart check**	
Diabetes Mellitus 1				
Diabetes Mellitus 2				**Weight**
Heart Disease				
Stroke				
Significant Renal Disease				**Recent Blood Pressure age 40 years and over**
Asthma				
COPD				

Do you have any Disabilities?

Do you have any Allergies? (e.g. to medicines, vaccinations, eggs, medical dressings, or food)

Any other relevant Medical History:

Current Medications: (Please note, we require 2 working days' notice for repeat prescription requests)

Smoking Status: Do you smoke? YES / NO Cigarettes per day.....

Pipe/Cigars..... eCig .....

Have you ever smoked? YES / NO Would you like help to give up smoking? YES / NO

Alcohol:

In an average week how many units of alcohol do you drink?
(1 unit = half pint beet, 1 small glass of wine, 1 single spirit)

Units per week:

If you have any concerns regarding your alcohol intake and would like some advice, please ask for details of how we can help when you have your New Patient Medical.

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Invitation to a Free NHS Health Check

If you are aged 40-74 years we would like to invite you to have a free NHS Health Check, please indicate below if you would like to have this check up.

I DO/ DO NOT want to have a free NHS Health Check

Please Sign .....

Carers

Are you a carer? YES / NO **Who for**: ..... **Relative / Friend / Other**
(Someone who regularly looks after or supports a person who is ill, disabled, frail or needs emotional support.)

Are You Cared For? YES / NO By Whom: ..... **Relative / Friend / Other**
(Do you need a friend or relative to help you with your day to day life?)

Would you like information about the Carer's Association? **YES / NO**

Consent to leave messages

This consent form will remain in force until notice of alteration by me.
In accordance with the Data Protection Act, the practice needs consent from any patient that has an answerphone and is happy for us to leave a message. If we do not have consent, we will be unable to leave a message on an answerphone or with a 3rd party.

I give consent to leave messages on my answerphone: YES / NO

Telephone numbers: ..... **and/or**: .....

I give consent for the practice to leave a message about any aspect of my medical treatment with:

Names: ..... **Date**:.....

Signed: .....

We want to be able to communicate better with our patients. It's important you can safely read and understand the information we send you. If you find that it's hard to read our letters or if you need someone to support you at appointments, please let us know. We want to know if you need information in large print, we want to know if you need a British Sign Language interpreter or advocate. We want to know if we can support you to lip read or use a hearing aid or communication tool. Please tell the receptionist when you arrive for your next appointment. Thank you.

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Permission to Share?

Our computer system is also used by other health units within the NHS. These include some A&E departments, other hospitals and physiotherapists. In order to provide more seamless care for you when you are seen by another health service we need to know if you are happy for us to share medical information that is held on our computers. Please note that you can change your mind at any time and your medical records will only be accessible by others who will also ask your permission. We all have patient confidentiality at the heart of patient care.

Are you happy:	yes	no
1) for your information on <u>our</u> computer to be seen by others treating you elsewhere?	☐	☐
2) for us to see your information <u>from other services</u>?	☐	☐

Signed…… (patient / parent / guardian / carer) please delete

Date……

Name……. (PLEASE PRINT)

Date of Birth……

Address……

……

Please note that you can change your mind at any time and your medical records will only be accessible by others who you give your permission to.

If you have any queries please ask at reception or see the Permission to Share leaflets.

<u>If you would like another copy of this form for other family members please ask at reception.</u>

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Application form for SystmOnline

Online appointment booking and cancelling, prescriptions management and summary record viewing

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Home Telephone: _____

Mobile Telephone: _____

Email: _____

Would you like to join our Practice newsletter mailing list? Yes/No

You **MUST** provide **photo ID** for your application to be accepted

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For office use only

☐ Passport/Driving License identification seen

Staff member **Date**

_____ _____

☐ Letter and password sent/emailed/given to patient

Date: _____ Signed: _____

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All relevant fields on the GMS1 form completed	
New Patient Questionnaire Fully Completed	
Forms of ID Checked	

Name of allocated GP ..... (Patient Informed) YES / NO

Checked by: Staff Name .....

Pack Includes

GMS1 Form
New Patient Questionnaire
New Patient Leaflet (one per family)
Consent to Share Form
Online Access to Medical Records Application Form