Saxon Cross Surgery

NHS
Nottingham West
Clinical Commissioning Group

New Patient Questionnaire

Full Name:	**DOB:**
Home number:	**Mobile number:**
Work number:	**E-mail address:**
Do you give consent for us to contact you via text message? YES NO *Please be aware if you say "NO" you **will not** receive appointment reminders via text*	
What is your preferred method of communication? POST SMS TEXT EMAIL (please circle)	

Marital Status: (Please circle)	Common Law Partnership	Divorced	Married
	Separated	Widowed	Single
Your Occupation:			

What would you consider your Ethnicity to be? (Please circle)			
African	Bangladeshi	British or Mixed British	Caribbean
Chinese	Indian or British Indian	Irish	Other Asian Background
Other Black Background	Other Mixed Background	Other White Background	Other
Pakistani or British Pakistani	White and Asian	White and Black African	White and Black Caribbean
Are you an English Speaker?	**YES** / **NO**	**First Language spoken:**	
Do you need an interpreter?			

Do you have any specific communication needs? *Please tick*			
□ Blind	□ Partially sighted	□ Deaf	□ Hearing Impaired
□ Memory problems	□ Learning disability	□ Autism	Please specify other:
If you ticked one of the above, how should we contact you? (If you would like us to contact you via another person please provide their details.)			

Next of Kin's Name:	**Relationship:**
	Contact Number:

If the patient registering is under 18 years old, please give us name and contact number of parents/guardians.	
Mother:	**Contact Number:**
Father:	**Contact Number:**
Local School/Nursery attended	

Are you a carer?
What relationship is the person you care for?

Do you have a carer?
Carers name:
Carers contact number:
What relationship is the person that cares for you?

Do you suffer from any of the following? (Please circle/Give details if necessary)			
Asthma	Epilepsy	Diabetes	Stroke
TB	Heart attack	Heart Problem	Cancer
Depression	Mental Health Illness	COPD	High Blood Pressure
Thyroid	Dementia	Atrial Fibrillation	
Any other important illnesses?			

Are you allergic to any medicines or dressings?	**Please give details:**

Please attach a repeat slip for any repeat medications you are currently taking

If you like to nominate a pharmacy to send your prescriptions electronically please give full details of the pharmacy here (name & full address):

Do you smoke?	**Are you an ex-smoker?**
If Yes how many a day?	**Would you be interested in smoking cessation advice?**
How many units of alcohol do you drink in a typical week? [ ] (one unit is a glass of wine, one measure of spirit or half a pint of beer)	
What is your height in metres?	**What is your weight in kg?**
Have you ever had an NHS Heart Check YES NO **If no and you are eligible for an NHS Heart check would you like arrange one YES NO**	

Summary Care Record - The intention of the SCR is to help clinicians in Hospital A&E Departments and GP 'Out of Hours' health services to give you safe, timely and effective treatment
See attached information on Summary Care Records for further information

[ ] I Express consent for medication, allergies and adverse reactions only

[ ] I Express dissent – I do not want a summary care record & fully understand the risks involved with this decision (If you wish to OPT out please complete the document attached)

EDSM – ENHANCED DATA SHARING MODEL (enhanced Summary Care Record) - Allowing your GP to share your record in the "SystmOne" database helps to deliver better and safer care for you

Sharing Out – Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that may care for you?	**YES NO** (please circle)
Sharing In – Do you consent to your GP Practice viewing data that is recorded at other NHS organisations and care services that may care for you?	**YES NO** (please circle)

To opt out of the Virtual Patient Participation Group (PPG) put a tick this box [ ]

Your allocated named General Practitioner will be Dr Rishi Mosaheb. However, we are a group practice and as such you are still able to see any GP for your problem depending on availability.

Would you like to register for online services (for example to book appointments with a GP/order repeat medication/see your medical record etc) **YES NO** (please circle)
If yes please complete the additional application form