**Registration Document Check List**

* Completed GMS1 Form
* Proof Of address and identification
* GDPR
* Completed New Patient Questionnaire
* Completed Alcohol Audit C Questionnaire
* Completed Minimum Standards of Behaviour Form
* Completed Mobile SMS Messaging Form
* Summary Care
* Access to online Services

Your name: ……………………………………….…….. Date: ……………………………

Address: ……………………………………………………………………………………….

Dear New Patient,

**Registering at Westbury Medical Centre.**

Thank you for applying to register at our practice. We kindly ask you:

1. Sign and Complete **all sections of the GMS1 registration form**
2. Provide one proof of residence address within the practice area from the list below and one proof of ID.
3. Provide proof of identification such as: Driving Licence, Passport, Birth Certificate, Bus Pass (Over 60’s)

**Any missing information will need to be completed BEFORE your registration can proceed. This is a requirement of the Health Authority.**

Proof of address from one of these (within the last 3 months, showing your name & address)

* Utility bill (gas electricity)
* House phone bill
* Rent book or tenancy agreement
* Home Office permit to stay
* On the electoral register (**students only 16-24**)
* Bank Statement
1. Please supply your land line and mobile telephone numbers and email address
2. Please fill in the New Patient Questionnaire, including the Smoking and Alcohol sections and the Data and SMS Texting consents.

If you take any regular medication please bring a copy of your repeat medication list

If you require language interpretation support for your appointment, please let us know.

Thank you

**Deborah Kelly – Practice Manager**

GDPR

**Patient Consent form**

I (NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONSENT TO THE BELOW NAMED PERSON TO:

COLLECT/ORDER PRESCRIPTIONS [ ]

BOOK/CANCEL APPOINTMENTS [ ]

PHONE TO COLLECT MY TEST RESULTS [ ]

SPEAK TO THE DOCTOR ON MY BEHALF [ ]

ACCESS MY MEDICAL RECORDS [ ]

NAMED PERSON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID SEEN BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Receptionist name)

 I **DO NOT** wish for any individual to have any access to my information. I understand that this means that only I can collect and order my prescriptions. Book or cancel my appointments and contact the surgery on my behalf.

 I understand that this is in accordance to General Data Protection Regulations Act, **NOT** data sharing through the NHS that may benefit my health.

|  |
| --- |
| Patient Name: |
| Patient Signature: |
| Date: |

**Westbury Medical Centre –**

**Behaviour Policy (Patient Copy)**

Thank you for asking to register at our practice.

We are committed to providing a pleasant and calm atmosphere while helping you with your Health Care Needs.

**We Wil:**

1. **Treat your affairs in strict confidence**
2. **Provide a good a quality service**
3. **Be courteous and professional**

We ask you to accept the minimum standards of acceptable behaviour. Failure to do so, may impede your registration being accepted.

Westbury Medical Centre adheres to a **ZERO TOLRENCE POLICY**

|  |  |
| --- | --- |
| **WHAT WE ASK OF YOU** | **WHAT WE MEAN** |
| Conduct and Civility to staff and Doctors | We will immediately remove any patient who swears or displays aggressive or violent behaviour. The police may be called in such circumstances. |
| Personal Hygiene and no immodest clothing. | Please try and be clean |
| Treat Premises with respect | No graffiti or vandalism. No eating, drinking or chewing gum. Help us to keep the premises Pleasant. (those caught vandalising the premises, depending on the severity of the damage- may be required to pay for damages incurred.) |
| Attend Punctually for appointments | Patients arriving more than 10 minutes late for an appointment will not be seen.Repeated missing of booked appointments may lead to removal from the surgery. |
| Attend surgery whenever possible | Best care can be provided in the surgery with the equipment and facilities we have here.Home visits can only be arranged for the elderly, infirm or house bound patients. |
| Sensible use of ‘out of hours’ service | Where possible it is always batter to come into the surgery during the day then call for a doctor at night. |
| Mobile phones switched off or on silent | Helps keep the waiting room pleasant and mobile phones could interfere with medical equipment |
| Complaints and suggestions are welcome | We are always looking to improve our services- any suggestions are welcome.Rarely a complaint maybe necessary; we will try and resolve this quickly. If necessary please address your complaint to the Practice Manager, or speak with the reception manager if available. |

Westbury Medical Centre, have a patient participation group that you are encouraged to join, if you would like to find out more information, please do not hesitate to contact us.

New Patients Questionnaire (Adult)

# Private and Confidential

**PATIENTS DETAILS**

|  |  |
| --- | --- |
| Surname: | First Name(s): |
| Date of Birth: / / | Gender: (Circle: Male / Female ) |
| Address:Post Code:  |
| Home Telephone: | Mobile Number: |
| Email: |
| Occupation: | Country of Birth:  |

|  |  |  |
| --- | --- | --- |
| Next of kin: Name & Relationship | Next of Kin Address | Next of Kin:Telephone number |
|  |  |  |

Ethnicity: (Please circle or write most appropriate)



**Main language spoken:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a carer? YES / NO Do you have a carer? YES / NO

Any other information you would like to provide:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Patient Statistics:** |
| Height: | Weight: |
| DIET: (Please Tick) |
| Balanced | Vegetarian | Vegan Diet | Weight Reducing | Other: |

|  |
| --- |
| **Lifestyle:** |
| Smoking Status: | Smoker (how many per day)[ ]Would you like help to stop smoking YES/ NO | Ex-smoker | Never Smoked |
|  |
| Exercise Status: | Light exercise | Moderate exercise | Heavy exercise | Never exercise |
| Exercise physically impossible: |

|  |
| --- |
| **Medical History** |
| Drug Allergies: |
| Food allergies:  | Animal allergies: | Other allergies: |
| SERIOUS ILLNESS/ OPERATIONS: |
| Do you have any long term conditions? Is so, please List. |
| CURRENT MEDICATION: (Please note if you are on repeat medication, you will need to see the Doctor before we can prescribe this for you). |
| Disability: YES / NO | Details: |

|  |
| --- |
| **Family History:** (Please state which member of your family has/had which condition) |
| Cancer: | CVA/TIA/ Stroke: | Thyroid Disease: | Diabetes: |
| CHD: | Hypertension: | Asthma: | Epilepsy |
| Other: |

**Travel Vaccinations:­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE ONLY**

|  |  |
| --- | --- |
| Date of last Smear (in UK): | Result:  |
| Are you taking any contraceptives? YES / NO | If ‘YES’ please state which type: |
| Have you had a mammogram? YES/ NO | If yes, please provide the date?  |
| Mammogram Normal? YES / NO | Did you require Treatment? YES/ NO |

**MALE ONLY**

|  |  |
| --- | --- |
| Family history of Prostate Cancer: YES / NO | **If yes: (who)**  |
| Have you had your prostate checked? YES / NO | If yes, outcome?: |

Do you drink alcoholic beverages? Yes / No

If yes, how many units do you drink per week?...............................................

**

***AUDIT – C***

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your****score** |
| 0 | 1 | 2 | 3 | 4 |
| **How often do you have a drink containing alcohol?** | Never | Monthlyor 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 thanmonthly | Monthly | Weekly | DailyOrAlmost daily |  |

**Score**

**Scoring:**

A total of 5+ indicated increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive

**Remaining AUDIT questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your****score** |
| **0** | **1** | **2** | **3** | **4** |
| **How often during the last year 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 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?** | Never |  | Yes, but not in the last year |  | Yes, during the last year |  |
| **Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?** | Never |  | Yes, but not in the last year |  | Yes, during the last year |  |

**Total score**

**Scoring:**

0 **– 7** lower risk, 8- 15 Increasing risk,

16- 19 Higher risk, 20 + Possible dependence

Westbury Medical Centre

Thank you for asking to register at our practice.

We are committed to serving your needs well.

We will:

* Treat your affairs in strict confidence
* Provide a good quality service
* Be courteous and professional

**We ask you to accept the following minimum standards of acceptable behaviour.**

|  |  |
| --- | --- |
| What we ask of you | What we mean |
| Conduct and civility to staff and doctors | We will immediately remove any patient who swears or who displays aggressive or violent behaviour. The police may be called in such circumstances. |
| Personal hygiene and no immodest clothing | Please try and be clean when attending your appointment. |
| Treat premises with respect | No graffiti or vandalism. No eating, drinking or chewing gum. Help us to keep our premises pleasant! (those caught vandalising the premises, depending the severity of the damage- may be required to pay for damages incurred) |
| Attend punctually for appointments | Patients arriving more than 10 minutes late for booked appointments will not be seen. Repeated missing of booked appointments may lead to you being removed from the surgery. |
| Attend surgery wherever possible | Best care can be provided in the surgery with the equipment and facilities we have here. Home visits can only be arranged for the elderly or infirm or housebound. |
| Sensible use of out of hours service | Where possible it is always better to come into the surgery during the day rather than to call for a doctor at night |
| Mobile phones switched off | Helps keep the waiting area pleasant and may interfere with medical equipment. |
| Complaints and suggestions are welcome | We are always looking to improve our services- any suggestions are welcome. Rarely a complaint may be necessary; we will try and resolve this quickly. If necessary speak to our Practice Manager |

|  |
| --- |
| **I have read and understand the minimum standards of acceptable behaviour.****Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient unable to read English. Advised patient to ask interpreter to read leaflet. |

MOBILE TELEPHONE SMS TEXTING POLICY

The increasing use of mobile phones has opened up a new avenue for communication between the Surgery and its patients. The immediate delivery of SMS messages gives it an advantage over other forms of communication. Text messaging has wide accessibility.

There are a number of scenarios in which an SMS message be very useful:

1. Appointment reminders

2. Flu vaccination reminders

3. Child immunisation reminders

4. Making patients aware of changes to clinics or services in the Surgery

5. Correspondence from the clinician regarding health and urgent matters

6. Opportunity to receive feedback on Surgery services

The usefulness of text messaging depends on having reliable data. We will check mobile telephone numbers as often as we can but **we ask that patients let the surgery know as soon as their mobile telephone number changes.** Mobile telephone numbers can be updated by calling reception or talking to the receptionists in the Surgery; they will be updated immediately. Patients are responsible for ensuring that the mobile phone number given to the Surgery is appropriate to be used for all communications that the Surgery may need to make. **Remember if you change your number. Let the surgery know!**

**Terms and conditions**

By signing this document you understand and authorise, Westbury Medical Centre to correspond with you regarding the above stated information. You accept that any changes to your contact information will be advised to the surgery at your earliest convenience, and that any information sent from the surgery through SMS during the time of inaccuracies are not liable to Westbury Medical Centre.

The text messaging provider that we use is known within the NHS. IPlato is an automated system linked with EMIS our clinical system. IPlato uses your information to enable us to provide this service to you and is not passed on to any 3rd party providers, excluding that of which would be classified as Direct Patient Care.

**Opting Out**

We understand that some patients will not want to receive SMS text messages from the Surgery. We ask that patients carefully consider the advantages of receiving these messages before choosing to opt-out. If patients are clear they wish to opt out, we ask them to write to the Practice Manager at the surgery indicating their name and mobile telephone number. When this letter has been processed, no more SMS messages will be sent to that mobile. Please note that the preference to opt-out of receiving SMS text messages from the Surgery will need to be renewed annually after 1 November.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile telephone number for SMS messages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
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|  |

 **Your Emergency care summary**

**Summary Care Record – your emergency care summary**

 Dear Patient,

 The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Also, if you specifically choose to do so, your Summary Care Record can hold other information you have agreed with your

GP Practice to have included.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England,

but they will ask your permission before they look at it.

This means that if you have an accident or become ill, the doctors treating you will have immediate access to important

information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

• **YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had**

• **YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Records**

• **NO I do not want a Summary Care Record**

If you know that a Summary Care Record was created for you by your previous GP Practice, we would still be grateful if you

could complete this form to confirm your current choice.

For more information talk to our Patient Advice and Liaison Service (PALS) **(0800 587 4132),** GP practice staff or visit the

website [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk)

Additional copies of the opt out form can be collected from the GP practice or printed from the website [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk).

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your**

**GP practice.**

Children under 16 will automatically have a Summary Care Record containing details of medications, allergies and bad

reactions created for them unless their parent or guardian chooses either to notify us that they would like their child to have

an enriched Summary Care Record (with other information agreed with the GP Practice to be included) or to opt them out.

If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make

this information available to them.

**Please return this form to the practice as soon as possible**

Yours sincerely

Practice Manager

|  |  |  |
| --- | --- | --- |
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|  |
|  |
|  |
|  |

 **Your emergency care summary**

My Summary Care Record Choice

1. Please complete in BLOCK CAPITALS

Title..................................................................Surname / Family name....................................................

Forename(s)................................................................................................................................................

Address.......................................................................................................................................................

Postcode .......................................... Phone No.............................................. Date of birth.......................

NHS Number (if known)..............................................................................................................................

If you are filling out this form on behalf of another person or a child, their GP practice will consider this request.

Please ensure you fill out their details in section A and your details in section B

Your name........................................................................... Your signature..............................................

Relationship to patient ............................................................................... Date ......................................

|  |  |
| --- | --- |
| **Summary Care Record Options** | **Please****Tick**  |
| **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had |  |
| **YES** I would like a Summary Care Record containing details of my medications,allergies and any bad reactions to medications I have had **AND** any other information thatI have agreed with my GP Practice to have included in my Summary Care Records*Please indicate what information you would like adding if you know* |  |
| **NO** I do not want a Summary Care Record |  |

**If you do not return this form, a Summary Care Record will be created for you based on implied consent.**

**What does it mean if I DO NOT have a Summary Care Record?**

|  |  |  |
| --- | --- | --- |
| NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines youhave had, in order to treat you safely in an emergency. | Your records will stay as they are now, with information being shared by letter, email, fax or phone. | If you have any questions, or if you want to discuss your choices, please:• contact your local Patient Advice Liaison Service (PALS); or• contact your GP practice. |

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

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| 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.  |  |
| 7. I understand that my email address can only be attached to my account. |  |
| SignatureDate |  |

# For practice use only

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