# AELFGAR SURGERY

**Church Street, Rugeley, Staffs, WS15 2AB**
**Tel: 01889 579276**
**www: aelfgarsurgery.co.uk**

## NEW PATIENT QUESTIONNAIRE

**PERSONAL DETAILS**

SURNAME : _____ FORENAME : _____

TITLE : MR/MRS/MISS/MS/OTHER DATE OF BIRTH : _____

ADDRESS : _____

POSTCODE : _____

TEL NO : (HOME) :_____ (MOBILE) : _____

EMAIL : _____

Do you consent to text/email reminders ? YES ☐ NO ☐

ARE YOU :

Single ☐ Married ☐ Cohabiting ☐ Separated ☐ Divorced ☐ Widowed ☐

**Are you a foster carer?** YES ☐ NO ☐

**Do you care for a child under a special guardianship order?** YES ☐ NO ☐

**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 : _____

Their telephone number :

**Do you have a carer?** YES ☐ NO ☐

If so, please complete the following :

Name of the person who cares for you : _____

Relationship to you: _____

Their address : _____

Their telephone number :

**If you would like your carer to be able to discuss your medical record with the clinicians please ask the receptionist for the appropriate form.**

**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 procedures**

| | | | |
|---|---|---|---|
| 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 | ☐ |

**Height and Weight**

Height :_____ Weight :_____

As a practice we offer new patient appointments, would you like to book one YES ☐ NO ☐

If you are on any repeat medication, please bring details of this with you on your first appointment with the GP or Nurse.

Would you like access to internet appointment booking/ordering prescriptions ? (If yes please complete the attached application form) YES ☐ NO ☐

**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 YES ☐

**No I do not want a Summary Care Record** – attached is an opt out form. Please complete the form and had it to a member of the reception team NO ☐

**SMOKING**

Do you smoke ? YES ☐ At what age did you start?

NO ☐ Have you ever smoked? YES ☐ NO ☐

What do you smoke? Cigars ☐ Cigarettes ☐ Pipe ☐ E- Cigarettes ☐ Cannabis ☐

How many do you smoke?

1 per day ☐ 1-9 per day ☐ 10-19 per day ☐ 20-39 per day ☐ 40 plus per day ☐

Would you like help to give up? YES ☐ NO ☐

**ALCOHOL**

How much alcohol do you drink?
Teetotal ☐

1 unit per day ☐ 1-2 units per day ☐ 3-6 units per day ☐ 7-9 units per day ☐ Over 9 units per day ☐

**Where 1 unit is equivalent to ½ pint beer, 1 small glass wine, 1 measure spirit.**

**EXERCISE**

Please tick the most appropriate

Exercise physically impossible ☐ Aerobic exercise 0 times/ week ☐ Aerobic exercise 1 times/week ☐ Aerobic exercise 2 times/week ☐ Aerobic exercise 3+ times/week ☐

**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 ☐

Our practice has a standard with regards to communicating with you and can use a variety of methods in order to do this. To ensure we promote the effective and clear policy by which ever means is appropriate to the circumstances, we would be most grateful if you could advise us if you require any of the following :

| Tick as appropriate | √ |
|---|---|
| Requires Audible Alert | |
| Using British Sign Language | |
| Requires information by email | |
| Requires written information in large font | |
| Requires information in Grade 1 Braille | |
| Requires information in Grade 2 Braille | |

**IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT**

When returning the completed registration form, please bring your proof of identification.

**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.**

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

# OPT-OUT FORM

## Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

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

Forename(s) .....

Address .....

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

NHS number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or 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 .....

### 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 you have 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:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no Date .....

## Application for online access to my medical record

| | |
|---|---|
| Surname | Date of birth |
| First name | |
| Address<br><br>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<br>Vouching ☐<br>Vouching with information in record ☐<br>Photo ID and proof of residence ☐ | |
| Authorised by | | Date | |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled<br>All ☐<br>Prospective ☐<br>Retrospective ☐<br>Detailed coded record ☐<br>Limited parts ☐ | | Notes / explanation | |

| **FOR PRACTICE USE ONLY** | Checked By (Initials) |
|---|---|
| Registration Form completed and signed | |
| New Patient Questionnaire completed | |
| SCR option selected (Opt-Out Form completed if dissent given) | |
| ID Verified and photocopied | |
| New Patient Health Check appt made | |
| Check if requesting online access and if so sign to say you have seen ID | |
| Communication Template completed | |