Bromleag Care Practice

Patient Registration Form – please PRINT and USE BLACK INK

All information supplied is treated confidentially and forms part of your medical record

Full Name: _____

Preferred Name: _____

Tel No Home: _____ **Mobile:** _____

Email address (must be different for each individual)**:** _____

Nominated Pharmacy for your medication: _____
(Please include the pharmacy's postcode)

Your medication will be sent electronically via the NHS' Electronic Prescription Service ("EPS"). For further information on the Electronic Prescription Service ("EPS"), please visit the NHS.uk website:

https://digital.nhs.uk/services/electronic-prescription-service

Please attach a copy of your latest list of medication to your application

If you reside in Extra Care Housing, please provide the name and contact details of your care provider below

_____

_____

NEXT OF KIN

Full Name: _____

Contact Telephone No: _____

Relationship to you: _____

Email address _____

Lasting Power of Attorney

Is there a Lasting Power of Attorney (LPA)? (if yes, evidence **must** be provided)

Health and Welfare: ☐
Property and Affairs: ☐

Name of nominated person: _____

Contact Details: _____

If your first language is NOT English, please complete

First language Spoken: _____ **Interpreter Required:** Yes/No

What is your ethnic group? (Please tick the appropriate)

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

CONSENT OPTIONS

If you require further information regarding consent please visit the Practice Website
www.bromleagcarepractice.co.uk

ONLINE ACCESS

We **strongly** recommend that you enrol for online access to your medical record for appointment booking and requesting medication. Access details will be emailed to your unique email address (email addresses cannot be shared).

If you require full access to your record please complete the form at the end of this document

Bromleag Care Practice sends appointment reminders, recalls and urgent messages via text.
It is your responsibility to notify us of any changes to your mobile number in writing.

If you wish to receive reminders you **MUST** consent here:

☐ I consent to receiving SMS text messages from Bromleag Care Practice

Getting in touch is sometimes difficult. Currently we do not leave voice messages without patient consent. Please indicate if you would like us to leave you a brief message.

☐ I consent for messages to be left on my mobile voicemail and understand my responsibility as set out below:-
It is essential that you ensure that we have the most up to date mobile number for you so please inform us if your mobile number changes.

In the future we may to wish to communicate with you via email. Please indicate if this would be a useful option for you and you would like to use this facility.

☐ I consent to receiving communication via email and understand my responsibility as set out below:

It is essential that you understand that you are responsible for ensuring that we have the correct email address and who has access to this information – *updates will only be accepted in writing via the change of details form.*

MEDICAL QUESTIONNAIRE

All new patients can book a new patient health check. Please ask Bromleag Care Practice for more information.

What was your past occupation? _____

Height: _____ centimetres **Weight:** _____ kilograms

Are you allergic to anything? Yes/No

If you answered yes to the above, what are your known allergies?

_____

_____

Smoking Status (please tick)
Never Smoked ☐
Current smoker ☐ _____ per day.
Ex-Smoker ☐ Quit in _____ (month/year)

Do you know your HIV status? Yes/No
If no we can offer a confidential HIV test, please ask at reception

We offer Hepatitis A & B vaccination if you are from an at risk area

Have any of your immediate relatives suffered from any of the following:-
(if any of the below are unknown, please fill in "Not Known")

Please tick as appropriate	Relative e.g. mother, sister	Under 60	Over 60
Angina or Heart Attack			
Stroke			
High Cholesterol			
Asthma			
Diabetes			
Cancer (please specify)			
High Blood Pressure			
DVT			
Osteoporosis			
Glaucoma			

Please add any other information that you would like the doctors to know about you. Please include any special requirements such as disability access

_____

_____

_____

ALCOHOL

Do you drink alcohol?

In moderation alcohol can be part of a healthy lifestyle, but excessive alcohol can be harmful to you. We would be grateful if you could answer the following questions as honestly and accurately as possible. To help answer the questions use the alcohol unit guide below to help estimate the amount of alcohol you drink.

I do not drink any alcohol (Teetotaller): ☐

No of units of alcohol per week: _____

	Questions	Scoring system					Score
		0	1	2	3	4	
1.	How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
2.	How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
3.	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 than monthly	Monthly	Weekly	Daily or almost daily	
						TOTAL	

Please score your questions. For example, if the answer to question 1 is 'monthly or less' this will score 1 for that question Add your scores for questions 1-3.

A total score of 4 or less for the above 3 questions is an indicator of a safe level of drinking.

If you total score is 5 or more then please continue with questions 4-10 on the following page.

	Questions	Scoring system					Score
		0	1	2	3	4	
4.	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5.	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	
6.	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	
7.	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8.	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	
9.	Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10.	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
If you have completed questions 4-10 this may indicate that there is a potential health implication due to drinking alcohol. We invite you to make a routine appointment to discuss this further. **TOTAL**							

Advanced Care Planning

The following questions will be in relation to your future care. Please take as much time as you need to carefully read through them, and answer appropriately.

In the event you become terminally unwell, have you thought about where you would prefer to be treated? If you are currently undecided, please don't hesitate to talk to your GP during review about your preference.

Please tick the appropriate box on the left-hand side.

Tick	Comment	CT Code (OFFICE USE)
	I am currently undecided	517161000000101
	Care Home	710571000000101
	Nursing Home	89761000000106
	Hospital	109401000000108
	Hospice	108401000000102

Is a treatment escalation plan in place? Yes/No

If yes, please provide details

_____

_____

Is there a Proactive Advanced Care Plan (PEACE)/Universal Care Plan UCP in place? Yes/No

Copy attached Yes/No

Is a Do Not Attempt Cardiopulmonary Resuscitation directive in place? Yes/No

If yes, what date was this put in place? ___/___/____

Deprivation of Liberty Safeguards (DoLS)

Please speak to the staff at the care home / extra care housing facility if you're unsure how to complete this section.

Is a Deprivation of Liberty Safeguards (DoLS) order in place? Yes/No

If yes, what date did this start? ___/___/____

If yes, what date is this due to expire? ___/___/____

If yes, please also provide a copy of the documentation received from the local authority for the patient's records.

MAKE APPOINTMENTS, REQUEST REPEAT PRESCRIPTIONS & VIEW YOUR MEDICAL RECORD ONLINE

Once you are registered for the Patient Access System you are able to; - make appointments, request prescriptions and view your GP medical record online. The Patient Access medical record viewer allows you to look at test results, details of consultations and your medical history, including current and past medication.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information provided below to set up and operate the service. **You will need to provide one form of photographic ID e.g. Passport or driving licence AND one form of non-photographic ID e.g**

The following form will take you through the things you need to think about. By signing this form you accept the declarations listed below and will be giving us your permission to go ahead with setting up the service for you (subject to your specific access requests). If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.

Conditions of Use and Declaration (please read the following and sign to accept):

1. I have read and understood this information leaflet about this service and access to GP medical records.
2. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not, access may be withdrawn.

3. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.

4. I agree that it is my responsibility to keep my username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.

5. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.

6. If I notice any inaccuracies with my record, I will inform the Practice Manager as soon as possible of any errors or omissions.

7. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.

8. I understand that, as before I will be informed directly by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.

KEEP THIS PAGE FOR REFERENCE

NEW APPLICANTS REQUIRING ONLINE ACCESS TO MEDICAL RECORD

Access to appointment booking and repeat medication requesting is automatically given

PATIENT DETAILS AND DECLARATION

Full Name of Patient:
Date of Birth:
Full Address
Postcode:
Contact Tel number:
E-Mail Address:

I have NOT yet registered and wish to request access to view my medical record ☐
I confirm that
☐I am the patient detailed above
Or
☐I have legal responsibility and consent to access the record of patient named above
All Applicants I have read and accept the conditions of use

Signed: _____ Date: _____

FOR OFFICE USE

Photo ID Confirmed (delete as appropriate)

Passport / Driving Licence / Other (please specify)**:** _____

Bromleag Care Practice

Application for Online Access (Proxy) to Services for Care Home Patients

Section 1- Patients Details

Patient Name		**Patient's Date of Birth**	
Patient Address	**Postcode:**		
Next of Kin / PoA (if applicable):			
Contact No:			

Section 2 – Application Type

I am requesting access to the online services of a patient and I have consent from the patient.		*Complete section 4A*
I am requesting access on behalf of the care home to the online services of the above patient. I am requesting this access based on the best interests for the patient and a next of kin is unavailable.		*Complete section 4B*
The patients' next of kin or legal power of attorney has consented to the Care Home having access to the above patient's online account for booking appointments and prescription ordering based on the best interests for the patient.		*Complete section 4C*

Section 3 – Terms of Agreement

I understand and agree with each statement below with regards to the patient's online information; *(Please tick)*

I have read and understood the information leaflet provided by the practice about online access and will treat the patients information as confidential	
I will be responsible for the security of any of the information that I see or download	
I will contact the practice as soon as possible if I suspect that the account has been accessed without my agreement.	
If I see information in the record that is not about the patient or is inaccurate, I will contact the practice as soon as possible. I will treat this information as strictly confidential.	

Section 4 – Consent

4A	Patient Consent; **Patients Signature:_____Date:_____**
4B	Best Interest Decision; **Care Home Managers Signature:_____ _____Date:_____**
4C	Consent from next of kin or legal power of attorney; **Next of Kin/Power of Attorney Signature:_____Date:_____**

Applicant's Name: _____
Applicant's Signature: _____ Date: _____

Section 5 – Consent for Access to Medical Records

To help facilitate the care of their residents, care homes may also request access to a resident's medical records via online services. This includes consultations, clinical letters, investigation results, and additional information which may have been entered into the patient's medical record.

Explicit written consent **must** be obtained from the patient or their Lasting Power of Attorney for Health & Welfare. Evidence must be supplied of the Power of Attorney.

All applications for access to a patient's medical records **must** be countersigned and authorised by the care home manager.

I am the patient as specified in section 1, and I consent for the care home where I currently reside to access to my medical records for the purpose of supporting my care. I understand that I can revoke this consent at any time by informing Bromleag Care Practice. I have indicated what information I would like the home to have access to by signing in the appropriate boxes below.

Patient's Signature: _____ Date: _____

I am the Power of Attorney for Health & Welfare as specified in section 1, and I consent for the care home where the patient currently resides to access the named patient's medical records for the purpose of supporting their care. I understand that I can revoke this consent at any time by informing Bromleag Care Practice. I have indicated what information I would like the home to have access to by signing the appropriate boxes below.

Power of Attorney's Signature: _____

Date: _____

Please sign in the box on the right-hand side to authorise access to this information

Immunisation records	
Investigation results	
Problem History (inc. major diagnoses, operations, fractures)	

Home Manager's Signature: _____ **Date:** _____

If you would like to learn more about Online Services by Proxy, please contact the practice.