Northlands Wood Practice
7 Walnut Park
Haywards Heath
West Sussex
RH16 3TG

Partners: Dr Liz Jenkins
Dr Ian Atkinson
Dr Huw Morris
Tel: 01444 458022
Fax: 01444 451960

www.northlandswoodpractice.com

NEW PATIENT REGISTRATION QUESTIONNAIRE

Please return this form once completed to reception.
To complete the registration we will need:

- **3 x blood pressure readings** (please use our machine located next to reception)
- Proof of ID and residency if you have them available.

OFFICE USE:
☐ Proof of ID & Residency
☐ Initials of person checking & date:
_____

TITLE:		FIRST NAMES:	
DATE OF BIRTH:		SURNAME:	
ADDRESS: Postcode			

Home Telephone No:	Mobile Telephone:	Work Telephone:

Email address: (please write clearly)	

Please ***tick*** and ***complete*** if you give us consent to contact you via the following:
(Please be aware that the contact/messages may contain confidential information about yourself.)

☐ EMAIL	☐ TEXT MESSAGE	☐ LEAVE VOICEMAIL ON **MOBILE PHONE**	☐ LEAVE MESSAGE ON **HOME** PHONE

☐ Please leave messages about any aspect of my medical treatment with (please print third party name):
_____

FIRST LANGUAGE:	My first language is:	Do you require a translator/ use of interpreting service?	YES/NO
ETHNIC ORIGIN:			

White ☐ British ☐ Irish ☐ White other (please specify):	**Mixed** ☐ White and Asian ☐ White and Black African ☐ White and Black Caribbean ☐ Other mixed background (please specify):	**Other Ethnic Group** ☐ Chinese ☐ Other ethnic group (please specify):
Black or Black British ☐ African ☐ Caribbean ☐ Other Black background (please specify):	**Asian or Asian British** ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other Asian background (please specify):	☐ I do not wish to disclose my ethnic origin

NEXT OF KIN: In case of an emergency, who would you like us to contact?			
Name		Relationship	
Address			
Home Telephone No.		Mobile No.	

SMOKING: Please tick all that apply to you	**WEIGHT:**
☐ I have NEVER smoked ☐ I STARTED smoking in ……(year) ☐ I STOPPED smoking in……..(year) ☐ I CURRENTLY smoke……. per day	_____ kg or _____ stones/pounds
	HEIGHT:
	___ cm or _____ feet/inches
	BLOOD PRESSURE: Please take 3 x readings at reception
	_____/_____ PUL_____

ANY ALLERGIES?: Please list below any medicine, substance, food, animal etc. to which you know you have an allergy	
☐ Yes: _____	☐ None

MEDICATION: Please list any regular medications you take:
Please make an appointment with a GP before you need to make your next prescription request

SOCIAL SERVICES: Are you known to or have contact with, Social Services?	☐ YES	☐ NO
If yes, please give details below:		

FAMILY HISTORY: Do you have a family history of the following?	Yes/No	Date diagnosed if known	Family member (mother, father, sister, brother, paternal or maternal grandmother/father, aunt etc.)
CHD (Coronary Heart Disease)			
Heart Failure (LVD)			
Hypertension			
Diabetes			
Asthma			
COPD (Chronic Obstructive Pulmonary Disease)			
Epilepsy			
Cancer			
Hypothyroidism			
Stroke or TIA (transient ischaemic attack)			
Mental Health			
CKD (Chronic kidney disease)			

Do you have a carer?	☐ Yes	☐ No
If yes, please give details of your carer:		
Are you a carer?	☐ Yes	☐ No
If yes, please give details of who you care for and in what capacity:		

OTHER MEDICAL INFORMATION: Is there any medical information you feel we should know before we receive your records?
If so please give details below:

ALCOHOL QUESTIONAIRE						
How many units of Alcohol do you drink per week? _____ 1 unit of alcohol = ½ pint average strength beer/lager OR 1 small glass of wine OR 1 single measure of spirit. 3-4 units of alcohol = high strength beer/lager. 10 units of alcohol = a bottle of wine.						
	QUESTIONS please circle your answers	0	1	2	3	4
1	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
3	How often do you have 6 or more units of alcohol on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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 expected from you because of 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?	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 regret 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 when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	Have you or someone 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 you cut down?	No		Yes, but not in the last year		Yes, during the last year
	TOTAL:					

Accessible Information Standard

We want to ensure that all communication we have with our patients is clear and set out in a way that is easy to understand. If you have a disability, impairment or sensory loss and you need us to communicate with you differently **please ask reception for an ACCESSIBLE INFORMATION STANDARD FORM.**

Summary Care Record: A Summary Care Record is a national electronic record which contains information about your medication, allergies and any bad reactions you have had in the past. In an emergency, Healthcare staff can use this information to treat you more easily, especially if your GP practice is closed.

- ☐ **I am happy to have a Summary Care Record (you do not need to do anything).**
- ☐ **I would like to opt-out of having a Summary Care Record – Please visit www.nhscarerecords.nhs.uk for further information and to complete the opt-out form or alternatively ask at reception.**

AGREEMENT STATEMENT

By being accepted as a patient at this surgery, the doctors and practice team make a commitment to look after your mediate and long term medical needs to the best of their ability under the NHS infrastructure. In turn, the practice expects you, as our patient, to attend for reviews, screening and to inform the practice if you cannot keep a booked appointment.

SIGNED…… DATE……

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PATIENT ACCESS gives you access to booking appointments online, repeat prescriptions & your coded medical record.

Please fill in the attached form in this pack and give to reception. You will need to bring proof of ID for reception to process the form for you. If you have provided us with your email address we will email you your personal password. If you don't have an email then we will contact you when your password has been generated.

Our Practice Guidance for Patient Access: regarding the booking of appointments and ordering of repeat prescriptions over the Internet. Please keep this page of the document for your own reference.

Repeat Prescriptions

You can use EMIS Access to order any repeat medications you are on. You cannot order one-off or acute medication as the doctor will need to see you before issuing these.

Appointments

Reasons for Appointment

We would ask that you enter a reason for your appointment in the box provided when booking an appointment this gives us the opportunity to ensure that it is appropriate for you to see the doctor rather than a nurse and helps the doctor to manage the clinical session. Please be assured that all details entered are secure and cannot be intercepted. Our practice has a strict confidentiality policy.

Reminder

If we have your mobile phone number, you will receive a text 48 hours before your appointment to remind you of the date and time.

Missed Appointments

Please let us know if you will be unable to attend an appointment that you have booked online. You can either cancel this online or contact us by telephone to cancel it. Please cancel in good time to allow us to offer the appointment to another patient. We realise that there are valid reasons for not attending however we will be monitoring such occurrences on a regular basis. **If you miss an appointment more than twice in one year we will remove your ability to use EMIS Access, however you will still be able to book appointments with our receptionists.**

Appointments

Due to the nature of nurses' appointments we are unable to offer them online at this time. If you are unsure as to whether it is appropriate for you to see a nurse or a doctor please telephone reception.

Inappropriate use

We monitor the use of this service and we are sure that you will find it useful. However if we find any abuse of the service, we will revoke your access to it. You will have to liaise with our reception team for services. We would consider inappropriate use as: Sending inappropriate or abusive messages, booking appointments and not using them more than twice a year, booking appointments for other family members using your name.

Your Responsibility

The practice will take every measure to ensure that your Patient Access application is secure. It is your responsibility to ensure that your Patient Access account remains this way. You are able to terminate or reset your Patient Access Account at any time by contacting the surgery in writing. You may wish to do this if you think someone else knows your login in details or if you have shared details with a family member or partner and no longer wish them to know these details.

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Dear Patient

The Practice is keen to set up a Patient Group and we would like to invite you to become a member of this group. We would like to hear your views on what works, what doesn't and what improvements you would like to see at the Practice.

- We are looking to involve as many patients in the group as possible, on a voluntary basis, so that we can shape and develop the services that we deliver to you, to make sure we offer you the services that you would expect and require. Your contribution would be valued and appreciated in helping us to help you, so we can give you the best quality health care. If you feel we do things well, we would like to know, so we can continue the good work!

What is involved?

Suggestions and Ideas
We would like to hear your views and ideas on what you would like to see from the surgery, so we can identify areas for improvement and influence the development of the local health services. We will gather this information by inviting you to participate in simple on-line surveys up to four times a year.

Your opinion
Occasionally we may contact you for your opinion on certain proposed changes.

Meetings
Members of the group will be invited to attend the Patient Group, perhaps twice a year, to discuss the focus of any changes to be made and the outcomes.

Topical Educational Events
We may offer topical educational events, if the members would like us to. Attendance will be offered primarily to Patient Group Members.

Reporting Back
We will publish on our website a report of the Patient Group activity and subsequent achievements.

Finally – if you would like to become a member of the Patient Group, please complete an application form either online via our website: www.northlandswoodpractice.com or contact reception.

Please note:

- No medical information or questions will be responded to.
- Individual complaints cannot be dealt with through the Patient Group. Complaints should be addressed to the Practice Manager. Copies of our complaints procedure can be found on our website or requested from the practice.

Please be assured that your contact details will be kept safely and securely, and not shared with anyone else.

The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.

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EMIS Patient Access Application Form (New Patient Questionnaire)

(If you require access for your child or person you care for please ask for a proxy access form)

Please be aware that if you are a new Patient that there may be a delay in giving you access to your coded medical record - until we have received your records in from the Health Authority.

Patient to complete:

Surname	Date of birth
First name	
Address 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		EMIS number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		Date passphrase sent
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes/explanation

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HEALTH VISITOR FORM

As Health Visitors we would like to make contact with you as a new family to the area. To help us we would be grateful if you could complete the following form and hand this to the Receptionist.

Please complete for **children under the age of six years**.
(If there are older children in the family too, please list their names and dates of birth just for our information, thank you).

CHILDREN UNDER THE AGE OF 6 YEARS:

Name	Date of Birth

OTHER OLDER CHILDREN IN THE FAMILY UNDER 17 YEARS OF AGE:

Name	Date of Birth

PARENTS' NAME(S)	Date of Birth
PRESENT ADRRESS: Post Code:	
Telephone Numbers:	
PREVIOUS ADDRESS:	
Previous GP:	