New Patient Questionnaire Form

Please complete ALL of this confidential questionnaire.

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**		
Title, please circle: **Mr / Mrs / Miss / Ms / Other (please specify) _______**					**Mobile Number:**		
Address and Postcode:					**Work Number:**		
					E-mail Address:		
					Can we contact you by text?	**Yes**	**No**
					Can we contact you by email? (if yes, we will send you a one off verification email that you will need to respond to)	**Yes**	**No**
Other residents of your home (if applicable):					**Next of Kin:** **Relationship to next of kin:** **Next of Kin Contact Number:**		
Your Date of Birth:		**NHS number:**					
Marital Status:		**Gender:**	**Male:**	**Female:**			
Occupation:		*If aged between 4 – 18 yrs old* **Current Place of Education:** **Start date:**			**Details of Previous Medical Centre Name & Address:** **Postcode:** **Telephone No:**		
Names and Ages of Children (if applicable): **Is there a Social Worker involved with the family? Y / N** **If Yes, please provide the name of the Social Worker and their contact details:**							
					If applicable, date you first came to live in Britain:		
Your height:	**Feet / inches**	**cm**	**Your weight:**		**Stones / lbs.**	**Kg**	
If you have not checked your weight in the last 3 months, please ask at the helpdesk to be weighed							

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated**

Your main or 1st language Spoken / Understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**BSL**	**Other:** (Please Specify)	
Will you need help in translation during contact with us? Y / N							

Smoking and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If you are a smoker we advise you to stop, as there are many health benefits from giving up. If you would like help and information on local smoking cessation services please ask us.					
How often do you exercise?	**No. times per week**		**Type(s) of exercise:**		

Your Medical Background:	
What health problems do you have or have had in the past and when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	
If on Warfarin, what type of regular blood test do you have? (Please tick one)	INR*/finger prick blood test ☐ ***OR*** Blood taken from a vein in your arm ☐

If you wish you can nominate a local chemist for your prescriptions to be sent to.	**Name and location of chemist:**					

Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g., swallowing, opening containers)

Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under 60 years of age	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important family illness?		

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any sensory impairment you have (i.e., speech, hearing, sight):	
Are you an 'assistance dog' user?	
Please state any physical disabilities you have:	
Please state any mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any religious or cultural needs:	
Do you require the help of a translator / interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	

Are you a carer?	Yes / No	*If "Yes", please provide the name and relationship of the person(s) you care for:*
Do you have a carer?	Yes / No	*If "Yes", please provide your carer's contact details:* *Sign here if you wish for us to disclose information about your health to your carer:* ___________________________
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If "Yes" Please bring a written copy of it into the surgery so we can add it to your medical records*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	*If "Yes", please state their name, relationship, address & phone number:* *And please bring a written copy of it into the surgery so we can add it to your medical records*

Have you ever served in the armed forces?	Yes / No

Do you have online access? If so and you would like to sign up to our online booking, medication ordering and medication/allergy history PLEASE ASK AT RECEPTION. They will require photo ID and we then provide you with a username & password.

We also provide an eConsult service where you can receive help, advice and treatment for your health problems online. Access eConsult via our practice webpage: www.litchdonmedicalcentre.co.uk

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It also means we can keep you informed of opportunities to give your views and update you with developments within the Practice.
If you are interested in getting involved, please provide your name, email address and contact telephone number and we will pass these details to the group coordinator.

Name:

Email address:

Telephone number:

***Alternatively, you can log onto our website at www.litchdonmedicalcentre.co.uk to join. Select the orange tab 'Join Our Patient Group' on our main homepage and follow the prompts.**

Patient signature:		Signature on behalf of patient:	
		Name of person signing on behalf of patient.	

Please tick the box confirming that you are happy for the surgery to send you text message reminders regarding appointments, services, and feedback on the service. ☐

For more information about the services we offer, please see our website: www.litchdonmedicalcentre.co.uk

Please complete this Alcohol Intake Screening questionnaire

Name: **Age:** **Date completed:**

This brief intervention package is based on the Drink-Less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study.
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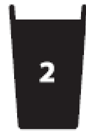
UNITS



Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

Please follow the instructions and complete the following questionnaire:

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standards drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If your score is 5 or more, please complete the additional questionnaire on the next page.

Additional questionnaire:

Name:

Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring System 0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

If your score on this sheet indicates hazardous or harmful drinking we would recommend you reduce your alcohol intake. If you would like help please make an appointment with the doctor or nurse.

SHARING YOUR NHS PATIENT DATA

With the development of information technology, the NHS will increasingly be sharing key information from your GP medical notes with Out of Hours GP Services, Hospital A&E Units, Community Hospitals, and Community Nurses - all of whom may at various times in your life look after you. Sharing information can improve both the quality and safety of care you receive and, in some cases, can be vital in making life-saving decisions about your treatment.

Information sharing in the NHS is subject to rigorous regulation and governance to ensure your full identifiable and personal medical data is kept confidential and only ever seen by carefully vetted doctors, nurses and administrative staff responsible for overseeing your care.

We will still require patient consent to allow the data to be shared (unless there are circumstances where a patient does not have capacity to consent, and clinicians will act in the patient's best interests).

Summary Care Record (aka SCR)

If you are registered with a GP practice in England your SCR is created automatically, unless you have opted out. Summary Care Records (SCR) are an electronic record of important patient information, created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system who are involved in your care (for example Hospitals, Out of Hours services and Ambulance paramedics).

Access to SCR information means that care in other settings is safer, reducing the risk of prescribing errors. It also helps avoid delays to urgent care.

At a minimum, the SCR holds important information about your

- current medication
- allergies and details of any previous bad reactions to medicines
- your name, address, date of birth and NHS number

You can, however, also choose to include **additional information** in the SCR, such as details of long-term conditions, significant medical history, or specific communications needs. This type of Summary Care Record is known as the **Additional Summary Care Record**. (this is recommended)

LOCAL SHARED CARE RECORD (Requires patient consent to opt in)

This is a Devon wide service initiative and includes: - Out of hours health services, hospital wards and A&E within Devon, Community Health services- such as District Nurses, Podiatrists, Occupational Therapists and SWAST (South West Ambulance Service Trust). It includes data such as recent diagnosis, test results, allergies, medications, current or past (and significant) illnesses, encounters and referrals.
Access will only be granted to health care professionals on a need to know basis with your consent.

Additional Summary Care Record (requires patient consent to opt in)

Benefits of using additional information in Summary Care Record

If you consent to the inclusion of **additional information** in your SCR, this will mean that more information will be available to health and care staff viewing the SCR. It will then be automatically updated when your GP record is updated. This is an effective way to:

- improve the flow of information across the health and care system
- increase safety and efficiency
- improve care
- respond to particular challenges such as winter pressures

It's particularly beneficial for patients who:

- have complex or long term conditions.
- suffer from frailty
- are eligible for flu vaccinations
- have dementia or learning disabilities
- have physical, sensory, or other disabilities, who can befit from recording any specific needs, for example communication needs, so that health and care staff can make reasonable adjustments
- are non-English speakers
- patients with carers whose details they want to share or who have appointed someone to have Health and Welfare Lasting Power of Attorney
- patients with specific care preferences

ENHANCED DATA SHARING MODEL (aka EDSM) (Requires patient consent to opt in)

The database and software used by our practice to store your GP health record is called “SystmOne” it is a very secure national system used by over 2000 GP practices and 4800 NHS organisations including GP out of hour’s services, children's services, community services and some hospitals. Most GP Practices in the North Devon locality use this same confidential clinical computer system. The system gives your GP the facility to share your record with other NHS health providers that use the same clinical computer system and are involved in your care for example the local Community Nurses who may look after you if you when you leave hospital or become terminally ill or housebound. Allowing your GP to share your record in the “SystmOne” database helps to deliver better and safer care for you. It is the policy of all local GP practices to automatically opt registered patients into “SystmOne” sharing unless they expressly decline. Those patients who choose to decline are able to determine if their data is “shared out” and/or “shared in”

Sharing **OUT** controls whether information recorded at our GP practice can be shared with other NHS health care providers.

Sharing **IN** determines whether or not our GP practice can view information in your record that has been entered by other NHS services who are providing care for you or who may provide care for you in the future (provided that you have consented to share out).

RESEARCH AND PLANNING

Research and planning - Information about your health and care helps the NHS to improve your individual care, speed up diagnosis, plan your local services and research new treatments.

In May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patient information safe and always being clear about how it is used. **You can choose whether your confidential patient information is used for research and planning.**

To find out more visit**: www.nhs.uk/your-nhs-data-matters** and Your Data Matters campaign at ico.org

SHARING YOUR NHS PATIENT DATA

Please complete and tick the boxes below to detail your personal decisions regarding the aspects of NHS patient data sharing.

It is very important you sign this form to say that you understand and accept the risks to your personal health care, if you do decide to opt out of SCR or EDSM.

Hand the completed form in to your GP surgery: they will scan this form into your NHS GP medical records and enter the appropriate computer codes.

When we refer you to another health professional for care, we need to give them your medical history, so they are aware of your health & any medication you are taking.
If for any reason you do not want us to share your medical history, please inform the doctor at the time of referral.

Patient full NAME	
Patient DATE OF BIRTH	

1. **SCR NHS SUMMARY CARE RECORD**

Please tick **only one box**

☐ **YES** Express consent for medication, allergies and adverse reactions only (XaXbY)

☐ **YES** Express consent for medication, allergies and adverse reactions and additional information (**recommended**) (XaXbZ)

☐ **NO** Express dissent – patient does not want a Summary Care Record and fully understands the risks involved in this decision. (XaXj6)

2. **EDSM – ENHANCED DATA SHARING MODEL "SystmOne".**

Sharing Out – Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that care for you?

☐ **YES** Share data with other NHS organisations (**recommended**)

☐ **NO** Do Not share any data recorded by my GP practice; I full accept the risks associated with this decision.

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?

☐ Consent given (**recommended**)

☐ Consent refused; I full accept the risks associated with this decision.

3. **Local Shared Care Record**

☐ **YES** I consent to a local Shared Care Record (XaKRv)

☐ **NO** I dissent to a local shared care record (XaKRw)

Patient/ parent/ guardian signature:	Date

*If you have any queries or questions, please contact the surgery on **01271 323443***

Or

*Email the surgery **D-CCG.AdminLitchdon@nhs.net***

Thank you for completing this questionnaire