GPS Healthcare

New Patient Registration - Adult

Accessibilty - If you require accessibilty support please circle below:

British Sign Lanuguage Interpreter **Large Print**

Audible Alerts **Other. Please specify**

Please complete the following actions in order for your registration to be completed

Please tick which site will be your usual site

Tanworth Lane Surgery		Meadowside FHC	
Village Surgery		Yew Tree MC	
Park Surgery		Knowle Surgery	

Complete the attached GMS1 NHS Registration Form
Complete the GPS patient registration form as fully as possible in block capitals
Provide proof of address e.g. utility bill
Photo ID (Adults only)
Immigrants passport for all adults and children (if appropriate)

Please ensure all of the actions above are completed in order for your registration application to be completed

Take your blood pressure using the machine in reception (if available) and enter the information on this form. If you are on regular medication please ensure that you request enough medication for one month from your current GP practice. This allows time for your registration to be processed. Please note that you will need to contact the practice for an appointment with a GP for a review of your medication.

All registered patients must have a named accountable GP (Usual GP). practice
Patients should be informed of their usual GP within 20 days of registration with the practice

Named Accountable GP:

Personal Details:			
Surname:		**Forename(s):**	
Address:			**Date of Birth:**
			Marital Status:
Postcode:			
Home Tel:		**Mobile:**	
Email:			

Consent:

I consent to receiving text messages for appointments, reminders **Yes / No**

I consent to receiving text messages relating to my healthcare **Yes / No**

I consent to receiving email messages for appointments, reminders **Yes / No**

I consent to the use of video consultation if and when required for my appointments **Yes / No**

Opticians:		**Dentist:**	
Contact Details:		**Contact Details:**	

Any other healthcare professional e.g. Chiropractor, Physiotherapist, Chiropodist

I give consent for you to contact the above healthcare professionals for the purpose of delivering the optimum primary service to you

Yes/No

Ethnicity

White	**Mixed**	**Black**	**Asian**	**Chinese**
White British	White/Black Caribbean	Black British	Indian	
White Irish	White/Black African	Black Caribbean	Pakistani	
White European	White/Asian	Black African	Bangladeshi	
		Black Other	Other Asian	

Any other ethnic category (please state): _____

Occupation:

Main Spoken Language: **Religion:**

Next of Kin: Name: **Relationship:**

Contact details of Next of Kin:

Profile

Height: **Weight:**

Blood Pressure: **Systolic BP:** **Diastolic BP:**

Smoking Habits:

Smoker **Y/N** **How many per day?** _____

What do you smoke? _____

If you would like help to stop smoking please book an appointment at reception

Never Smoked: **Ex Smoker:** **When did you stop:** _____

Alcohol

One alcohol unit equals one 25ml single measure of whisky (ABV 40%), or a third of a pint of beer (ABV 5 - 6%), or half a standard glass of red wine (ABV 12%)

Please complete the following by circling the appropriate answer

Do you drink alcohol? Yes / No

How often do you have 8 (men) 6 (women) or more drinks on one occasion

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

In the last year has a relative, a friend, a doctor or other health professional been concerned about your drinking or suggested you cut down?

No/Yes/On one occasion

Exercise

Do you get:	**No Exercise / Little Exercise / Regular Exercise** (please delete as appropriate)
If yes what sort of exercise?	
How many times per week?	

Family History

Does anyone in your family suffer with the following? If so please state who

	Who?	**Date of onset/Diagnosis**
Heart Disease (Heart attacks, Angina)		
Stroke		
Diabetes		

Current Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of Drug		**Name of Drug**	
Dosage		**Dosage**	
Name of Drug		**Name of Drug**	
Dosage		**Dosage**	
Name of Drug		**Name of Drug**	
Dosage		**Dosage**	

All prescription requests in GPS Healthcare are sent electronically.

Please nominate a pharmacy for future prescriptions to be sent electronically:

Pharmacy Name & Address:

I consent to Electronic Repeat Dispensing Yes/No

Electronic Repeat Dispensing (**eRD**) allows your prescriber to authorise your repeat medications in advance. This avoids you needing to remember to request your medications from the practice and wait for them to be made ready. With **eRD** your medications are automatically made ready at the pharmacy in time for your next collection.

Allergies & Sensitivities

Are you allergic to any medication? If yes please detail below

Yes / No

Are you allergic to any substances or foods? If yes please detail below

Yes / No

Carers

Do you have anyone who looks after you or your daily needs as a carer?

Yes / No

If yes would do you give consent for them to deal with your health matters?

Yes / No

Please provide details of you carer:

Do you look after someone who is ill frail, disabled or mentally ill?

If so you are a carer and we would like to support you. If you are agreeable we will pass on your details to Solihull Carers which is a borough wide organisation providing relevant information and advice, local support services, and a telephone helpline for carers.

We can also refer you with your permission, to have your needs assessed by Adult Care Services. A carers assessment is a chance to talk about your needs as a carer and the possible ways help could be given. It can also look at the needs of the person you care for. This can be done seperately or together depending on your circumstances. There is no charge for this assessment.

Details of the person you look after:

Name:	

DOB:		**Telephone No:**	

Address:	
Post Code:	

Please pass on my details to Solihull Carers **Yes / No**

Please refer me to Adult Care Services for assessment **Yes / No**

Armed Forces

Are you a veteran of the Armed Services? **Yes / No**

If yes which one? _____

Are you in the employ of the Armed Services? **Yes / No**

If yes which one? _____

Past Medical History

Please give details of any significant past medical history or hospital treatment:

Do you have any disability, impairment or any sensory loss? **Yes/No**

If yes please give details below

Do you have any particular communication needs which are related to your disability, impairment or sensory loss?

If yes please give details below

Whilst you are under no obligation to answer the following question, this information allows the practice to ensure services are provided where thay are needed and that our healthcare is tailored to your individual needs. Please remember that **ALL** staff within the practice are bound by strict rules of confidentiality and noone wil disclose information without your permission.

Which of the following options best describes how you think about yourself?

Heterosexual ( ) **Lesbian ( )** **Gay ( )** **Queer/Other ( )**

Bisexual ( ) **Other (Please state)** _____

Gender Identity

Male ( ) **Female ( )** **Other (Please state)** _____

Trans - Male to Female ( ) **Trans Female to Male ( )**

Thank you for completing this questionnaire. Please return to reception with some form of photo ID e.g. passport or driving license ***AND*** *a utility bill or bank statement(within the last three months) of your current address*

Official Use Only			
Form of ID seen		**Date:**	
Staff Signature		**Staff Initials:**	

DATA SHARING INFORMATION

HOW WE CAN USE YOUR DATA TO IMPROVE YOUR CARE

Summary Care Record

Your Summary Care Record will hold the following information:
Allergies and adverse reactions
Acute medication
Repeat medication
Discontinued medication in the last 6 months

Your Summary Care Record could be accessed, with your permission, by participating hospitals throughout the UK if you needed care.

A Summary Care Record will automatically be created on completion of your registration unless you advise us to the contrary in writing.
If you do not wish to have a Summary Care Record created, please contact the surgery within 2 weeks of your registration.

If at any time you wish to OPT OUT of the Summary Care Record please contact the surgery on 0121 796 2777.

Your Care Connected

This is a more detailed record that can be shared with local hospitals and community services throughout Solihull, Birmingham and Sandwell. This enables all organisations to share important details of your medical history along with investigations, test results, medication etc.

The aim is to improve communication across local GP's, hospitals and community services, avoid duplicating investigations such as blood tests and also prevent patients from having to repeat their "story" at every service.

"Your Care Connected" Record will automatically be created unless patients advise the

If at any time you wish to OPT OUT of Your Care Connected please contact the surgery on 0121 796 2777

Name..... Date of birth……

Signature..... Date……

The following service is an "Opt-In" Service. You do need to complete the section below so

SystmOne Enhanced Data Sharing

SystmOne is a clinical computer system produced by a company called TPP. It lets NHS staff record patient information securely onto a computer. This information can then be shared with other clinicians, if needed and agreed by you, so that everyone caring for you is fully informed about your medical history, including medication and allergies. In Solihull, many GP practices, HEFT Community services, The Walk in Centre and Marie Curie all use SystmOne so that patients can really benefit from joined up care.

With your permission we can make your medical record shareable (Sharing Out). You will then be asked, when you attend other services, whether you are happy for them to access your record for information to improve your care and you can make a decision for each individual service i.e. you may want the district nurses to be able to access your record but if you are attending the smoking cessation service, you may not feel that they need to see your record. You will also need to tell each service if you are happy for them to let your GP see details of the treatment you receive from that service (Sharing In).

Further information can be obtained from reception if needed.

Sharing Out – I would like to make my record shareable so that other services can access it when I give them my permission to

Consent to share record

Name: ----------

Date of birth: ---------- **Signature:** ----------

Date: ----------

Sharing Out – I would not like to make my record shareable so that other services can have access to it

Dissent to share record

Name: ----------

Date of birth: ---------- **Signature:** ----------

Date: ----------