Albion House Surgery

PARTNERS:

Dr A J Young
Dr I A Reed
Dr C R Edwards
Dr D P Heys
Dr S Saeed
Dr M Parkes
Dr N Kaur

ASSOCIATES:
Dr F Couth
Dr R Marns

Welcome to AW Surgeries

New Patient Registration Pack

Thank you for choosing AW Surgeries as your GP Practice. To complete the registration process please:-

- Check that your address is within our practice area.
- Make an appointment with one of our Health Care Assistants for a registration interview.
- Complete the registration forms (for each family member) and bring to your appointment along with the following:
  - Photographic proof of your identification i.e. passport/driving licence.
  - Proof of your address i.e. a utility bill.
  - An early morning urine sample.
  - Any regular medication you are taking or repeat prescription list from your last GP.

If you are unable to keep your registration interview appointment please telephone appointments on the number below to cancel or re-arrange.

We would ask you to be aware that failure to attend your registration appointment will invalidate any future appointments and you will not be invited to join this practice.

The Practice offers On-line services where you can book appointments, order your repeat medication and view your immunisation history. If you would like to take advantage of this service please ask at your registration interview.

Patient Name:…….EMIS Number:……

Date of Interview:…….Nurse/HCA:……

Identification checked: Photo I.D Proof of Address:

Have you ever been in the Armed Forces Yes/No (Regular/Reserves)

Exercise	Height	Weight	BP	Urine

Have you had any serious illnesses or operations? If so please list below:

.....

.....

.....
.....

Please List any Medications you take regularly:

.....

.....

.....
.....

Please list any Allergies:

.....
.....

Do you smoke?	Are you an Ex-smoker?	Never smoked?
How many per day?	When did you give up?	

Female Patients Only Date of last smear…….....

IMMUNISATIONS FOR Under 5's only

DTaP/IPV/Hib (1)	DTaP/IPV/Hib (2)	DTaP/IPV/Hib (3)	Hib/MenC	DTaP/IPV **or** dTaP/IPV
Pneumococcal	MenC	Pneumococcal	Pneumococcal	MMR
Rotavirus	Rotavirus		MMR	

NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✔ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

NHS Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register Date _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: .....

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Alcohol history (**over 16's only)** Units per week ……..

Questions 1 – 3 New patient screening (9K17)	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 alcohol drinks do you have on a typical day?	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	
Total **Score over 5 please complete questions 4 - 10**						
Questions 4 – 10 Full assessment (9K15)						
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 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 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	
Total						
Leaflets/Advice given by nurse (**brief intervention**) (9K1A) **Yes/No**						
Does the Patient wish to be referred for advice **(extended intervention)** (9K1B) **Yes/No**						
Refer for specialist advice (8HKG) **Yes/No**						

MEETING EVERYONE'S HEALTH NEEDS

We would be very grateful if you could take time to complete this form. Please remember it is voluntary and any information given will be treated confidentially. If you have any queries about completing this form, please ask a member of staff. For question 1, if you feel you are descended from more than one group, please tick the one you feel you most belong to, or choose the "any other ethnic group" option. We are also asking your religion, preferred language and whether you have a disability. Again this is to help us ensure we meet your health care needs appropriately. Please hand in the completed form to staff. Thank you.

1. Please tick which ethnic group you feel you belong to?

A. White
- o British
- o Irish
- o Any other white background

B.Mixed
- o White & Black Caribbean
- o White & Black African
- o White & Asian
- o Any other mixed background

C. Asian or Asian British
- o Indian
- o Pakistani
- o Bangladeshi
- o Any other Asian background

D. Black or Black British
- o Caribbean
- o African
- o Any other black background

E. Any Other Ethnic Group
- o Chinese
- o Yemeni
- o Travellers
- o Any other, please describe

- o Do not wish to state

Date of Birth……..……..……..

Family name / Surname…….

Personal / First name…….

2. Which religion do you practice?

- o Buddhist
- o Christian (including C of E, Catholic, Protestant and other Christian faiths)
- o Hindu
- o Jewish
- o Muslim
- o Sikh
- o Any other religion (please state)

- o None
- o Do not wish to state

3. What is your preferred language? (Please choose one)

	Written	Spoken
Arabic		
Bengali		
Chinese/Cantonese		
English		
Gujarati		
Hindi		
Punjabi		
Urdu		
	Spoken/Visual	
Mirpuri		
Pashto		
Pathwari		
Sylheti		
British Sign Language		
Other, please describe		
Do not wish to state		

Please tick if…….

- o You have a disability

- o You are registered disabled

CARERS IDENTIFICATION AND REFERRAL FORM

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?

If so, you are a carer. Please complete this form and hand back to reception.

If you are agreeable, we will pass your details to the Carers Service, which is a countywide organisation providing relevant information and advice, local support services, newsletter and telephone linkline for carers.

We will 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 could be done separately, or together, depending on the situation. There is no charge for an assessment.

YOUR DETAILS:

Name	
Date Of Birth	
Address	
Post Code	
Telephone Number	
Relationship to Patient	
Signature & Date	

DETAILS/AUTHORITY FROM THE PERSON CARED FOR:

Name	
Date Of Birth	
Address (If Different From Above)	
Post Code	
Telephone Number (If Different From Above)	
GP Details (If Different From Your Own)	
Next of Kin details	
Emergency Contact details	
Permission to discuss record	
Signature and Date	

□ Please pass my details to the Carers Service.
□ Please refer me to Adult Care Services for a Carers Assessment

Thank you for completing this form

MEDICAL STUDENTS.

We currently teach medical students from Birmingham University.
We teach students from years 1 to 5 and as part of their education they have to talk to patients with various problems and backgrounds.

We would be very grateful if you would consider taking part in the medical student training that this practice undertakes.

If you decline or wish to withdraw your consent at anytime your medical treatment will not suffer in any way.

PATIENT CARE TEXT MESSAGING

The practice offers a text messaging service for the purposes of appointment reminders to your mobile telephone number.

The responsibility of attending appointments or cancelling them still rests with the patient. The patient can cancel the text message facility at any time.

The surgery does not offer a reply facility to enable patients to respond to text messages directly.

Text messages are generated using a secure facility. However they are transmitted over a public network onto a personal telephone. The practice will not transmit any information, which would enable an individual patient to be identified.

Patient Declaration: I agree to advise the practice if my mobile number changes or if it is no longer in my possession. The Practice will continue to use the number given unless advised otherwise.

GIVING YOUR CONSENT – please complete details and sign below

I would be willing to see a Medical Student	**Yes / No** please circle as appropriate
I give my consent to receive text messages	**Yes / No** please circle as appropriate

Name:.....D.O.B:.....

Address:.....

Telephone No:.....

Signature:.....Date:.....

The practice does not share mobile phone contact details with any external organisation.

Important information about your Summary Care Record

Dear patient,

The NHS in England has introduced the Summary Care Record, an electronic health record that can be accessed when you need urgent treatment from somebody other than your own GP.

Summary Care Records contain key information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. You will be able to add other information too if you and your GP agree that it is a good idea to do so.
If you have an accident or fall ill, the people caring for you in places like accident and emergency departments and GP out of hours services will be better equipped to treat you if they have this information. Your Summary Care Record will be available to authorised healthcare staff whenever and wherever you need treatment in England, and they will ask your permission before they look at it.

You need to make a decision

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

• Yes, I would like a Summary Care Record:-
If you want a record you do not need to do anything further, one will be created for you when you register with your GP practice. If you opted out of having a record in the past but have now changed your mind, speak to your GP practice and they can create one for you.

• No, I do not want a Summary Care Record: -
If you do not want a record, you need to fill in the Summary Care Record opt out form and hand it in to your GP practice. You should do this even if you have already completed a form at your previous practice. Opt out forms are available from your GP practice or you can print one from the website below.

You are free to change your decision at any time by informing your GP practice.
Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, please tell them about Summary Care Records and explain the options available to them.

For more information talk to your GP practice, or call the Health and Social Care Information Centre on 0300 303 5678.

Yours sincerely

AW Surgeries

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

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 a 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 contact your GP practice.

FOR NHS USE ONLY

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

Ref: 4705

Patient Panel Group

Would you like to have a say about the services provided at AW Surgeries?

New members are always welcome.

If you can spare some time please join us.

The panel meets monthly for about an hour alternating between Albion House and Withymoor

If you would like to join please contact Geoff Lawley (chairman) 01384 822172

Or

Stuart Steele 01384 443133 / 07950116828
Stuartsteele48@hotmail.co.uk

Alternatively you can email the Patient Panel with you views on

patientpanel@hotmail.co.uk

or hand your comments into reception for the attention of the patient panel

Our Patient Panel encourages patients from all backgrounds and age groups to give their views about how the practice is doing. They would like to be able to ask the opinions of as many patients as possible and are asking if you would like to provide your email address so that they can contact you every now and again to ask you a question or two.

Are you interested in leaving your email contact details?

If you are interested please fill in this form and hand it back to reception. We will be happy to pass your details on to the Patient Panel.

Your details will only be used for this purpose and will be kept safely.

Name…….....……

Email address…….....……

Signature……

Date…….

I agree to my details being used by AW Surgeries Patient Panel as detailed above	Yes / No

.