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NEW PATIENT REGISTRATIONS

Welcome to Solent View Medical Practice. To ensure the smooth transition from your previous surgery we please ask that you ensure the following requests are adhered to

Please complete all the relevant sections before returning to the surgery. Please bring two forms of ID, one of which must be photographic ID, for example, passport, driving licence. The other must be an official letter confirming your new address. If you are unable to provide either or both of these please discuss this with the receptionist.

The new patient pack contains information about how data that we hold about you is used. Please read this section carefully, before completing and signing, as your decision regarding sharing data can affect your future medical care away from the surgery

**What we ask from new patients:**

* **Please ensure you have enough medication from your previous surgery to last 4 weeks to enable us to fully complete your registration.**
* **Bring a list of medication you are currently on if possible – for example a repeat prescription slip from your previous surgery.**
* **Provide as much information as possible on the registration forms.**

All new patients, over the age of 16, will be offered a New Patient Medical with the practice nurse. This will ensure that all your registration details are correct and that your blood pressure, weight, height and lifestyle information are recorded in your records to assist with your future care.

We expect all booked appointment to be attended but if you are unable to attend, or no longer require the appointment, please let reception know as soon as possible so that we can offer it to another patient.

Please note, we do not take prescription request over the telephone and all medication requests will take three working days to process.

URGENT CARE CLINIC

Solent View Medical Practice operates a daily Urgent Care Service Monday to Friday. This is for urgent medical problems that cannot wait for a routine appointment. It is not for review of pre-existing conditions, medication reviews, sick note requests or minor illnesses that can be self-managed or dealt with by other healthcare providers (such as the pharmacist).

Please give the Care Navigator some basic information of your symptoms/ problem that day and they will advise the best action to take (for example Minor Injuries Unit, Pharmacist, routine appointment or Urgent Care). Please provide a contact number for a call from the urgent care team.

There are several alternative ways to access medical care and advice. Solent View Medical Practice uses e-consult as a way of contacting the GP when an appointment is not available. Please see our website [www.solentviewmedicalpractice.co.uk](http://www.solentviewmedicalpractice.co.uk) or our Facebook page for more information.

**Please complete all pages using BLOCK capitals**

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| **MEDICAL REGISTRATION FORM – Over 16yrs** |
| Full Name |  | Gender |  |
| Previous Last Name/s |  |  |  |
| Address & Post Code |  | Date Of Birth |  |
| Home Telephone |  | Mobile Telephone |  |
| Email Address |  |
| Place of Birth (Town and Country |  |

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| **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 |  |

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| **If you are from abroad:** |
| Your first UK address whereRegistered with a GP |  |
| If previously resident in UK date of leaving  |  |
| Date you first came to UK |  |

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| **Next of Kin** |
| Full Name |  |
| Relationship |  |
| Contact Telephone |  |
| **Please note that this consent will remain in place until your inform us otherwise** |

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What do we use your mobile phone & Email address for? We may send you texts or emails for:

Appointment reminders

Information regarding health campaigns such as Flu vaccinations

Message you regarding test results

If you do not wish to be contacted in this way please let reception know.

Do you consent to be contacted by:

Text Yes / No

Email Yes / No

Voicemail Yes / No. Are you happy for a message to be left? Yes / No

Who can we leave a message with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Military Veteran** |
| Are you a Military Veteran ?  | Yes | No |
| Are you a Member of a Military Family (Spouse or Dependant Child)? | Yes | No |

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| **Communication Requirements** |
| Do you have any special communication requirments? | Yes | No |
| If yes please state: |

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| **Ethnicity/Language** Please indicate your ethnic origin |
| White British | Asian | Other |
| White Irish  | Mixed White/Black African  | Declined to state |
| White Other  | Mixed White/Black Caribbean |  |
| Black British | Mixed White/Asian |  |
| Black African | Indian |  |
| Black Caribbean  | Chinese |  |
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| Main spoken Language |
| Please advise if a translator is required | Yes | No |

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| **Personal Medical History**  |
| **Do you have an ongoing medical condition? If so please list below** |
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| **Please List Any Medications That You Take** |
| **Medication Name** | **Dosage** |
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| **Prescriptions will be sent direct to your chosen Pharmacy,** **Please state the name and address of the Pharmacy you use:** |

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| **Please list any allergies you have:** |
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| **Carers** |
| Are you a carer?  | Yes | No |
| Do you have a carer?  | Yes | No |
| If yes, please tell us the name & address of yourCarer: |  |
| Are you happy for us to contact your carer about you? | Yes | No |
| **This carer’s information will remain in place until you inform us otherwise** |

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| **Smoking**  |
| Do you smoke: | Yes | No |
| If yes, do you smoke | Cigarettes | Cigars | Pipe | Roll Own |
| How many per Day | 1 – 9 | 10 – 19 | 20 – 39 | 40+ |
| Are you an ex-smoker? | Yes | No |
| If yes, what date did you stop? |  |
| How many did you used to smoke per day on average? |  |

IF YOU ARE A SMOKER AND WANT TO STOP, CALL 0845 602 4663 FOR FREE ADVICE

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| **Family Medical History**  |
| Has either of your parents or any of your siblings had Angina or a Heart Attack before the age of 60? | Yes | No |
| If yes please give details |  |

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| **Female patients only**  |
| Are you currently, or think you may be pregnant?  | Yes | No |
| Date of your last cervical smear test?  |  |
| Have you had a Total Abdominal Hysterectomy? If yes please state year   |  |

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| **Lifestyle alcohol** |
| See the source image |
|  | 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink that contains alcohol? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How many units do you have on a typical day when you are drinking? | 0 - 2 | 3 – 4 | 5 – 6 | 7 – 9 | 10 + |
| 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 |
| How often in the last year have you found you were not able to stop drinking once you have started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 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 |
| How often in the last year have you needed an alcoholic drink in the morning to get you going after a heavy drinking session? | 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 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 |
| Have you or someone else been injured as result of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

Scoring

● 0 to 7 indicates low risk

● 8 to 15 indicates increasing risk

● 16 to 19 indicates higher risk,

● 20 or more indicates possible dependence

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| **Patient Participation Group** |
| Would you like to join our Patient Participation Group and be able to give your views on how the Practice is doing? | Yes | No |

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| **Data Sharing and You** |

Medical Records & Data Sharing explained:

As part of the NHS, our surgery aims to provide you with the highest quality of health care. To do this we must keep records about you, your health and the care we have provided or plan to provide to you. These records may include:

* Basic details about you such as address, telephone number, date of birth, next of kin
* Contact we have had with you such as clinical visits
* Notes and reports about your health
* Details and records about your treatment and care, including test results
* Relevant information from people who care for you and know you well such as health professionals and relatives

Everyone working for the NHS has a legal duty to keep information about you confidential. We have a duty to maintain full and accurate records of the care we provide to you.

Some information will be held centrally to be used for statistical purposes. In these instances we take strict measures to ensure that individual patients cannot be identified. We use anonymous information, wherever possible, but on occasions we may use personal identifiable information for essential NHS purposes such as research and auditing.

**We will not share information that identifies you for any reason unless:**

* You ask us to do so
* We ask and you give us specific permission
* We have to do this by law
* We have special permission for health and research purposes, or
* We have special permission because the interest of the public are thought to be of greater importance than your confidentiality, for example, if you had a serious medical condition that may put others you may have come into contact with at risk
* When we use this information we make sure that, wherever possible, we do not use personal details such as your name and address, in order to protect your confidentially. When releasing information to researchers, we give them only the minimum data necessary and all their research is carefully vetted.

**At the surgery there are three main organisations with which we share your data:**

**Summary Care Record**

There is a national NHS Computer System called the Summary Care Record (SCR). This is an electronic record, which contains information about the medicines you take, allergies you have and any bad reactions to medicines you may have had.

Having this information stored in one place makes it easier for healthcare professionals to treat you in an emergency, or if your GP practice is closed. This information could make a difference to how a doctor decides to care for you, for example which medicines they choose to prescribe you.

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| If you **WISH** to have your data uploaded as a Summary Care Record please tick here  |  |
| If you **DO NOT** **WISH** to have your data uploaded as a Summary Care Record please tick here  |  |

You can add more information such as your health problems, carer details or communication needs to your SCR. This is called an enhanced SCR so if you ever needs treatment away from your GP surgery, health care staff will have a better understanding of your needs and preferences.

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| If you **WISH** to have your data uploaded as an enhanced Summary Care Record please tick here  |  |
| If you **DO NOT** **WISH** to have your data uploaded as an enhanced Summary Care Record please tick here  |  |

For further information visit the NHS Digital website

**Care and Health Information Exchange (CHIE)**

The Care and Health Information Exchange (CHIE) is a secure system which shares key parts of your electronic record from GP surgeries, hospitals, community, mental health and social services. It allows health professionals across Hampshire and the Isle of Wight to provide safer and faster treatment for you and your family.

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| If you **WISH** to have a CHIE record please tick here  |  |
| If you **DO NOT** **WISH** to have a CHIE record please tick here  |  |

**Care and Health Information Analytics (CHIA)**

Your information is also used to improve future care for you, your family and for other patients. This helps plan NHS services and supports medical research. To keep your information safe it is moved to a separate database called ‘Care and Health Information Analytics’ (CHIA) and changed so that it **cannot be used to identify you.**  Your data is never shared for the benefit of commercial companies like drug manufactures. People who analyse data on CHIA **do not have** access to CHIE, so cannot identify you.

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| If you **WISH** to have a CHIA record please tick here  |  |
| If you **DO NOT** **WISH** to have a CHIA record please tick here  |  |

**Signature**

I confirm that the information I have provided in this form is true to the best of my knowledge.

Signed: Date:

Signature of Patient Signature on behalf of patient

**We do not tolerate aggressive, threatening or abusive behaviour towards any staff and Patients will be removed from our practice list if there are occurrences of unacceptable behaviour**