Vassall Medical Centre

New Patient Health/Registration Questionnaire

It is important that the surgery gathers as much information about the health status of each patient wishing to register, as this information may well be connected to certain medical conditions.

Your previous medical records may take up to 6 weeks to reach us, so in the meantime, it is good practice to provide the clinicians with as much information as you can. Please note that all information provided will be confidential.

Your Details

Title:____ Surname:_____ First Name:_____

Date of Birth:____/____/_____ Home Tel No:_____

Mobile Tel No:_____

Work Tel No:_____ Marital Status:_____

Occupation:_____

Email Address:_____ (block capitals please)

Patient Access - Office Use Only

Identity Verified: ☐ Yes ☐No

Record Access: ☐ Core Record Given ☐ DCRA Given

Verified by:_____

ID Provided:_____

Date:_____

What do you consider to be your national identity?_____

What is your country of birth?_____

What is your main spoken language?_____

What language do you prefer to read?_____

What is your religion? _____ Religion none ☐

Please turn over

Please tell us your ethnic group. Please choose one section only from A to E. In that section please tick the most relevant box. If you tick a box marked other, please write your ethnic group in the space given.

A. Asian or Asian British	B. Black or Black British	C.Chinese or Other Ethnic Groups
☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other_____	☐ African ☐ Caribbean ☐ Any other black background _____	☐ Chinese ☐ Any other ethnic group _____
D. Mixed Background	**E. White**	If you do not wish to state your ethnicity please tick here ☐
☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐ Any other mixed background _____	☐ British ☐ Irish ☐ Any other white background _____	

Please tick as appropriate:

I need an interpreter or translator ☐ *Yes* ☐ *No*

I can read English ☐ Yes ☐ No

Do you need large print? ☐ Yes ☐ No

Do you use lip reading? ☐ Yes ☐ No

Do you use textphone/minicom? ☐ Yes ☐ No

Do you rely on British Sign Language? ☐ Yes ☐ No

I do not read ANY language and someone helped me to fill in this box ☐ Yes ☐ No

SCCI1605 the Accessible Information Standard directs and defines a specific, consistent approach to **identifying, recording**, **flagging**, **sharing** the information and communication support needs of patients, service users, carers and parents, where those needs relate to a **disability, impairment or sensory loss.**

Do you feel you require communication support based on the above criteria?
☐ **Yes** ☐ **No**
(if your answer is no the please continue to "Your Health Details", if it is yes the please answer the following questions)

What type of communication support do you use?

☐ Legal Advocate	☐ Citizen Advocate	☐ Use a hearing aid	☐ Use sign language
☐ Use British sign language	☐ Use Makaton sign language	☐ Use Lip reading	☐ Use Manual note taker
☐ Use electronic note taker	☐ Use speech to text reporter	☐ Use Cued speech transliterator	☐ Use Lip speaker
☐ Use Textphone	☐ Use alternative communication skill	☐ Use Communication Device	☐ Use deafblind intervener
☐ Use Tadoma method for communication	☐ Use Communication aid	☐ Use Deafblind manual alphabet	☐ Use Symbols for communication

Do you use a personal communication passport? ☐ Yes ☐ No

What is your preferred method of communication?

☐ Speech	☐ Written	☐ British Sign Language

What is your preferred method of contact?

☐ Telephone	☐ Text relay	☐ SMS text	☐ Letter
☐ Email	☐ Audible alert	☐ Visual alert	☐ Tactile alert

Do you require a specific Information format?

☐ Verbally	☐ DVD	☐ CD	☐ Cassette
☐ Easyread	☐ Email	☐ MP3	☐ Moon Alphabet
☐ Makaton	☐ Grade 1 Braille	☐ Grade 2 Braille	☐ Written in 20pt Sans Serif
☐ Written in 24pt Sans Serif	☐ Written in 28pt Sans Serif	☐ USB Mass Storage	☐ Downloadable format
☐ Healthcare info on personal audio recording			

During a consultation do you require any of the following?

☐ Interpreter needed – British Sign Language	☐ Interpreter needed – Makaton Sign Language	☐ Need an advocate	☐ Deafblind Communicator Guide
☐ Sign supported English interpreter	☐ Deafblind manual interpreter	☐ Deafblind manual alphabet interpreter	☐ Deafblind Block alphabet interpreter
☐ Deafblind haptic interpreter	☐ Manual note taker	☐ Lipspeaker	☐ Visual frame language sign

Please turn over

			interpreter
☐ Hands on signing language interpreter	☐ Speech to text reporter	☐ Communication partner	☐ Sighted guide
☐ Third party to read out written information			

Your Health Details

Have you had any serious past illnesses or operations? ☐ Yes ☐ No

*If yes please give details*_____

Has any of your immediate family i.e. parents, sisters or brothers suffered any of the following;

Heart Attack ☐ Yes ☐ No Over 60 ☐ Yes ☐ No Under 60 ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Blood Pressure ☐ Yes ☐ No

Are you following a special diet? ☐ Yes ☐ No

Weight Reducing ☐ Yes ☐ No Low fat or cholesterol ☐ Yes ☐ No

Low Salt ☐ Yes ☐ No Milk Free ☐ Yes ☐ No

High Fibre ☐ Yes ☐ No Vegetarian ☐ Yes ☐ No

Gluten Free ☐ Yes ☐ No

Are you allergic to any foods or medication? ☐ Yes ☐ No

*If yes please give details*_____

_____

What is your height?_____

What is your weight?_____

In your opinion which of the following exercise categories applies to you?

Exercise is physically impossible ☐

I avoid even trivial exercise ☐

I enjoy light exercise ☐

I enjoy moderate exercise ☐

I enjoy heavy exercise ☐

Are you on any regular medication? If yes, please give details

_____

_____

When was your last smear test? (females only)_____

Was your last smear test normal?_____

Please tick the appropriate box and answer the linked questions

☐ Never Smoked ☐ Ex-Smoker

How many did you smoke per day?_____ How long were you a smoker?_____

When did you give up?_____

☐ Current Smoker How many do you smoke per day?_____

How long have you been smoking?_____

Would you like us to help you stop smoking? ☐Yes ☐No

Please provide details of your next of kin. This is the person we will contact in the event of an emergency.

Full

Name:_____Relationship:_____

Address:_____

Postcode:_____

Tel No:_____

FAST Alcohol Screening Test

Questions	Scoring System 0	1	2	3	4	Your Score
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 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	
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	
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	

How many units do you drink per week?_____

Would you like a HIV Test?

Yes ☐ No ☐

If you have answered yes then please read the following information. When you have finished, please sign, date and return the completed form to reception.

- New patients registering at this practice are being offered an HIV test. This is due to there being high rates of diagnosed and undiagnosed HIV infection in Lambeth.
- Having an HIV test is the only way to know for certain whether or not you have HIV.
- If you have HIV and don't know it, then your immune system will slowly become damaged. If it is diagnosed, then your health can be monitored and you can have treatment to keep you well.
- If you have HIV and don't know it, you could pass it on without realising.

You will be given a form to have the test at St Thomas Hospital or Kings College Hospital Dulwich or Gracefield Gardens in Streatham if this is more convenient.

If you require further advice or have any questions about your blood test then please ask to speak to one of the Doctors or Practice Nurses,

Please telephone the surgery for your results which will be available one week after your test.

If your test is positive (i.e. you are found to have HIV) then one of the doctors will speak to you by telephone to discuss further care and advice.

Please note that it can take up to a month for your body to recognize HIV and for this to show up in a blood test. Therefore, if you think you might have been at risk of contracting HIV then please repeat the test in 4 weeks time.

All results are confidential and cannot be shared with a third party. Having an HIV test does not affect any treatment you receive.

I agree/ do not agree to have a HIV blood test. I have read the information given to me and understand I should call for my results after one week.

Signature:

Name:

Date:

Please turn over

Appendix 10 - Patient Nomination Request (Consent Form)

Electronic Prescription Service

Patient Nomination Request

NHS England

Patient name…… DOB ……..……..

NHS Number ……..

Address Telephone Number

…… ……

.....

Post Code.....

Nomination has been explained to me by staff at my GP practice / community pharmacy / appliance contractor and I have also been shown the patient information leaflet that explains nomination.

I have read the leaflet 'Explaining the Electronic Prescription Service – Information for Patients and carers in England' and understand what I have to do.

I confirm that patient nomination has been explained to me and I understand what I am consenting to.

I confirm that I have made my nomination of my own free will and have not been influenced or given a gift to select a particular nomination and that I can change my mind at a later date.

Name and address of nominated dispenser (please print)

……

……

Please cross out where appropriate:

I am the patient named above / carer of the patient named above**.**

Patient/Carer

Name:……..

Signature:……

Address If different from above:

……

……

Date……

Staff Name: ……..

Staff Signature: ……..

Please turn over

How we share your data

Important – Please read the following two pages carefully

Summary Care Record

All patients who have chosen to, have a Summary Care Record which is used nationally and contains important information from the record held by your GP practice such as details of any medicines you are taking, any allergies you suffer from and any bad reactions to medicines that you have previously experienced. Your Summary Care Record also includes your name, address, date of birth and your unique NHS number to help identify you correctly.

Summary Care Records are accessible to authorised healthcare staff treating patients in an emergency in England. All information is confidential and only accessible to staff with NHS Smartcards. When we register you as a patient; unless you specify below that you dissent from having a Summary Care Record we will take it as presumed consent and create a Summary Care Record for you. You can dissent by by signing the agreement below but please note that not sharing your information may affect the care you receive.

*If after reading the above you **do not** wish to have a "Summary Care Record" please ask for a dissent form.*

Local Care Record

Local NHS organisations have a duty to keep complete, accurate and up-to-date information about your health, so that you can receive the best possible care. Sometimes the people caring for you also need to share some of your information with others that are also supporting you. This could include GPs, hospital based specialists, nurses and health visitors. To support this information sharing to happen more quickly and to improve the care you receive, a new process has been put in place in Southwark and Lambeth. This will join-up your care records from local hospital organisations (Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts) with GP practice information through existing computer systems. It is called the ***Local Care Record***.

Information is only shared when it is needed to make your care and treatment safer, easier and faster and only with those people directly involved in your care. This could include allowing a hospital doctor to see the medication that a GP has prescribed for you when you go in to hospital or allowing a GP to see what care, tests or treatment you received while in hospital. Above all it will allow professionals that are supporting you to work with you to make safer and better decisions about your care.

Please turn over

The new system will start to operate in a small number of GP practices and hospital services in August 2015, and other organisations will continue to join during 2015 and 2016. The doctor or healthcare professional treating you will inform you that they are accessing your shared Local Care Record.

However, in an emergency situation where you may not be conscious or able to give consent, they will access your information to give you the best care. You can choose for your information not to be shared between your local NHS organisations by signing the agreement below, but please note that not sharing your information may affect the care you receive and will not allow you to visit a GP Hub.

*If after reading the above you **do not** wish to have a "Local Care Record" please ask for a dissent form.*

Thank you for completing this questionnaire