STATION VIEW HEALTH CENTRE

Thank you for applying to join Station View Health Centre we would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving licence) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Fields marked with an asterix (\*) are mandatory.

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| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First names |
| \*Any previous surname(s) | |  | \*Date of Birth |
| \*Male Female Intermediate Unspecified | |  | \*NHS No. |
| Town and country of birth | |  | \*Home address & Postcode  \*Previous address & Postcode |
| Home telephone No. Preferred Number Yes No | |  |
| Work telephone No. Preferred Number Yes No | |  |
| Mobile No. Preferred Number Yes No | |  | Email address |
|  | | | |
| \*Previous GP Details | |  | If you are from abroad please tell us 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: |
|  | Marital Status?  Single Married Divorced Widowed Co-habiting |
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**Additional details about you**

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| --- | --- | --- | --- | --- | --- | --- |
| What is your ethnic group?  Main Language Spoken?  (E.g. English) | | | | | | |
| **White**  **Black**  **Asian**  **Mixed**  **Other** |  | British  Caribbean  Indian  White + Black Caribbean  *Please specify*: |  | Irish  African  Pakistani  White + African |  | Chinese  White + Asian |

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| **Have you ever been in the employ of the Armed Forces?**  Yes  No  ***Personnel Number:*** ***Date Enlisted: Date Left:***  **Are you a dependant of a current serving member of British Armed Forces?**  Yes  No |

**Next of kin \ Emergency contact**

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| --- | --- | --- |
| Name of next of kin \ Emergency contact |  | Relationship to you |

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| Next of kin \ Emergency contact telephone number(s) |  | Next of kin \ Emergency contact address (if different to above) |

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**Data Sharing**

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| **Summary Care Record (SCR)**  Your SCR is an electronic summary of key medical information taken from your GP medical record. If you need healthcare away from your usual doctor’s surgery, your enhanced SCR will provide those looking after you with key information to help them give you better and quicker care. Please refer to **‘What is a Summary Care Record’** document for more information **or visit:** [**https://digital.nhs.uk/summary-care-records/patients**](https://digital.nhs.uk/summary-care-records/patients)  **Tick this box if you wish to have an enhanced SCR with core and additional information (recommended)**  Tick this box if you wish to opt-out of the SCR  Office use only code 9ND7  Initials |

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| **Medical Interoperability Gateway (MIG)**  The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care you will be asked if you consent to the care service seeing essential elements of your record.  **More information can be found by visiting: http://www.healthcaregateway.co.uk/products**  **Tick this box if you wish to opt-out of the MIG data sharing** |

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| **Risk Stratification Preferences**  **Risk stratification** is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Station View Health Centre is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.  **For more information please visit our website at www.stationviewhealthcentre.co.uk**  **Tick this box if you wish to opt-out of the Risk Stratification programme** |

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| **Enhanced Data Sharing Module (EDSM)**  Station View Health Centre use a clinical computer system called EmisWeb to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use Emis Web. These other services will always ask consent to view your record. **For more information please visit our website at www.stationviewhealthcentre.co.uk**  **Tick this box if you wish to opt-out of the Enhanced Data Sharing Module** |

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| \*Do you consent to receive the following types of communication (if offered) from Station View Health Centre?  **Email** Yes No  **Mobile phone text messages** Yes No  **Answering machine messages** Yes No |

**Carers Information**

*A carer is a friend or family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided.  A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.*

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| Are you looked after by someone who’s support you could not manage without? Yes No  If yes, what is their name and contact number?  Do you consent for your carer to be informed about your medical care? Yes No |

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| Do you look after or support someone who couldn’t manage without you? Yes No  If yes, do you look after someone who is a patient of Station View Health Centre? Yes No  Don’t know  If yes, what is their name?  Are they a: Relative Friend Neighbour |

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**Medical details**

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| **In order to continue to receive your repeat medications you’ll need to make a new patient health check appointment and bring in your last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with your repeat medication list found on the right hand side or a printed prescription.** |

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| \*Are you allergic to any medicines?  Yes  No (if yes please specify) |

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| \*List other allergies / intolerances (i.e. nuts, gluten, pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of) |

**Have you ever had any of the following conditions?**

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| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | Yes | Year |  | **Mental Illness** | Yes | Year |
| **High Blood Pressure** | Yes | Year |  | **Diabetes** | Yes | Year |
| **Heart Attack / Angina** | Yes | Year |  | **Asthma** | Yes | Year |
| **Stroke / Mini-stroke (TIA)** | Yes | Year |  | **COPD (or Emphysema)** | Yes | Year |
| **Cancer** | Yes | Year |  | **Osteoporosis / Bone fractures** | Yes | Year |
| **Rheumatoid Arthritis** | Yes | Year |  | **Peripheral vascular disease** | Yes | Year |

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| Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs. |

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| **The Accessible Information Standard (AIS)**  Please use this space to tell us about any specific communication needs you have. I.e. needing information in large print or deafblind telephone contact. For further information please visit **https://www.england.nhs.uk/ourwork/accessibleinfo/** |

**Do you have family history of any of the following?**

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| **High Blood Pressure** | Yes | Who |  | **DVT / Pulmonary Embolism** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged >60 yrs | Yes | Who |  | **Breast Cancer** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged <60 yrs | Yes | Who |  | **Any Cancer**  Specify type: | Yes | Who |
| **Raised Cholesterol** | Yes | Who |  | **Thyroid disorder** | Yes | Who |
| **Stroke / CVA** | Yes | Who |  | **Epilepsy** | Yes | Who |
| **Asthma** | Yes | Who |  | **Osteoporosis** | Yes | Who |

**Please tell us about your smoking habits**

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| Do you smoke?  Yes  No  If Yes, what do you primarily smoke:  Cigarettes / Cigar / Pipe (please circle) |  | Are you an ex-smoker  Yes  No  When did you quit?  How many did you used to smoke a day? |
| How many do you smoke a day?  Would you like advice on quitting?  Yes  No |  |  |

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**Please tell us about your alcohol consumption**

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| **Questions** (please circle your answers) | **Unit scoring system** | | | | |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times  Per month | 2 - 4 times per week | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 - 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 |
| **Depending on your answers above you may be asked to complete an additional alcohol questionnaire.** | | | | | |
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| Do you exercise regularly?  Yes  No  If so – What exercise do you take?  How often? |
| (**for women only**) Have you had a cervical smear?  Yes No (*Please state where, when and the result if possible*) |
| \*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.  I give consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)  I give consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)  IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Please record any additional information about you that you think is important for us to know** |

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| **Electronic Prescription Service (EPS)**  EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.  If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service, please talk to your pharmacist of choice. |

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| **Patient Participation Group (PPG)**  Would you like to join the PPG? |

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| **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  **For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23** |

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| --- | --- | --- |
| **\*Signed** |  | **\*Date / / /** |

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| **Signed on behalf of patient** (*if applicable*)  (e.g. for minors under 16 years old, adults lacking capacity) |  |
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**Once you are registered…**

You will be asked to sit and wait while we register you this should only take a few minutes in case we need to clarity any problems during the registration process.

On-line Services

…You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet.  All of the details that you need for this are available by requesting to be registered at reception.

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| **FOR OFFICE USE ONLY** |
| **PHOTO ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Over 18 only)  **ADDRESS ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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