****

New Patient Registration Form

7-9 Manchester Road

Haslingden

BB4 5SL

Tel **01706 253700**

Please Complete in **BLOCK CAPITALS**

1. **Patient Details** (If Patient is aged under 16 Section 2 is also required)

|  |  |  |
| --- | --- | --- |
| Surname |  | |
| First Names |  | |
| Date of Birth |  | |
| Address |  | |
| Postcode |  | |
| Home Tel |  | |
| Work Tel |  | |
| Mobile |  | Can we contact you by text?\* Yes No |
| Email |  | |

\*The Surgery communicates via the MyGP App

2. **Parent / Guardian / Foster Carer Details** (if patient is under 16)

|  |  |  |
| --- | --- | --- |
| Relation to patient |  | |
| Surname |  | |
| First Names |  | |
| Date of Birth |  | |
| Address |  | |
| Postcode |  | |
| Home Tel |  | |
| Work Tel |  | |
| Mobile |  | Can we contact you by text? Yes No |
| Email |  | |

3. **Online Access** You will be given Online Access at the point of Registration.

Please bring **Two Forms of ID** to prove your Identity.

One must be Photographic (e.g. Passport / Driving License)

One must be Proof of Address (e.g. Utility Bill / Council Tax Bill)

The Surgery Communicates via the My GP App which is supported by East Lancs CCG

4. **Your Ethnicity** (please circle)

|  |  |
| --- | --- |
| British/Mixed British | African |
| Bangladeshi | Caribbean |
| Chinese | Indian |
| Pakistani | Other (please state): |

5. **Asylum / Refugee Status** (please circle)

|  |  |  |
| --- | --- | --- |
| I am an Asylum Seeker | I am a Refugee | N/A |

6. **Chronic Conditions** Do you suffer from any of the following (please circle)

|  |  |
| --- | --- |
| Asthma | Emphysema / Lung Disease |
| Atrial Fibrillation | Epilepsy |
| Cancer | Heart Attack / Coronary Heart Disease |
| Chronic Kidney Disease | Hypertension |
| COPD | Stroke |
| Diabetes | Thyroid Problems |

Please note that if you have circled any of the above you must book an appointment for a New Patient Health Check

7. **Smoking Status** (please circle and complete as appropriate)

|  |  |
| --- | --- |
| Never Smoked | Passive Smoker |
| Current Cigarette / Roll Up / Cigar / Pipe Smoker | - Amount smoked per day: |
| Ex-Smoker Cigarette/ Roll Up / Cigar / Pipe | - Amount previously smoked per day: |

8. **Alcohol Consumption** (please circle)

a) How often do you consume alcohol (male) 8 or more drinks (female) 6 or more drinks?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Less than Monthly | Monthly | Weekly | Daily/Almost Daily |

b) 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/Almost Daily |

c) How often during the last year have you failed to do what was normally expected of you due to drinking?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Less than Monthly | Monthly | Weekly | Daily/Almost Daily |

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

|  |  |  |
| --- | --- | --- |
| No | Yes But Not Last Year | Yes During The Last Year |

9. **Carer Status** (please circle)

|  |  |  |
| --- | --- | --- |
| I Am a Carer | I Have a Carer | N/A |
| If you circled ‘I Am a Carer’ or ‘I Have a Carer’ please provide details: | | |

10. **Allergies** Do you have any allergies, or have you ever had an allergic reaction after taking a drug?

No

|  |
| --- |
| Yes (Please give details): |

11. **Repeat Prescriptions**

If you have any repeat medications please bring in a copy of your Repeat Slip and hand it in to Reception.

12. **Veterans** Are you a Veteran of the Armed Services? Yes No

13. When you hand in this form you will be asked to use the Height / Weight / Blood Pressure machine at Reception. This is Free of Charge.

14. **Communication / Access** Do you have any communication or Access needs?

No

|  |
| --- |
| Yes (Please give details): |

15. **Summary Care Record**

If you have previously registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past. Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your Options are explained below:

|  |
| --- |
| • Express consent for medication, allergies and adverse reactions only. You wish to share information about medication, allergies for adverse reactions only. |
| • Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you. |
| • Express dissent for Summary Care Record (opt out). Select this option, if you DO NOT want any information shared with other healthcare professionals involved in your care. |

Please tick as appropriate:

**Yes – I would like a Summary Care Record**

Express consent for medication, allergies and adverse reactions only.

or

Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

Express dissent for Summary Care Record (opt out)

16. **Policies**

|  |
| --- |
| **Your Rights and Responsibilities** |
| All information about our patients is treated as strictly confidential. Electronic data kept on computer by the practice complies with the General Data Protection Act (GDPR). No member of Hazelvalley Family Practice will discriminate or treat unfairly a member of the practice, patient, or member of public attending Hazelvalley Family Practice on the grounds of gender, race, nationality, ethnic origin, colour or creed, age, marital status, disability, medical condition, social background or sexual orientation.  **If you change your contact details you must inform The Surgery immediately.** |

|  |
| --- |
| **Registration Health Check** |
| All new patients over the age of 40 are invited to make an appointment for a health check. This will take around 20 minutes and will be with our HCA or Practice Nurse.  We also require any patient with any of the conditions detailed in **Section 6** to attend a registration health check. This is to ensure we can give you the care you require and gives us up to date information about your health. |

|  |
| --- |
| **Chronic Disease and Medication Monitoring** |
| We require any patients with Chronic Disease or who take Medications that require Monitoring to attend Review Appointments at intervals set by the GP.  Attendance of these Appointments is compulsory in order for the GP to manage your condition and prescribe safely. |

|  |
| --- |
| **DNA Policy** |
| If a patient fails to attend a pre-booked appointment on more than one occasion in the last 12 months, an informal warning letter will be sent to the patient, advising them that a further occurrence could risk removal from the practice.  If the patient fails to attend a 2nd appointment a formal warning letter will be issued.  If the patient fails to attend their 3rd appointment after their formal warning letter they will be removed from the practice list. Warning letters are valid for 12 months. |

17. **Your named accountable GP will be Dr Mannan**

18. By signing you agree to have read and understood the policies shown above.

|  |  |
| --- | --- |
| Signature of Patient |  |
| Date |  |
| (For Admin use only) | * Controlled Drugs Policy Signed |
|  | * ID Checked (for online access only) * (AIS) Ask patient if they have any information or communication needs. Add to notes. |
| Updated: 16.01.2020 | * Codes 9NN60 and 67DJ added to notes * Codes added for Carer, Asylum Seeker/Refugee |

19. Please note, the attached form will only be accepted if the following Controlled Addictive Drugs Patient Agreement is also signed. Please see next page.

|  |
| --- |
| **Controlled/ Addictive Drugs Patient Agreement**  \*\*\* This Section Must Be Completed\*\* |
| Do you take drugs of addiction or drugs which could potentially cause significant harm?  i.e. Morphine, Tramadol, Gabapentin Diazepam, Tamazepam (Please note this list of drugs is not exhaustive)  No (sign **Section A**) Yes (Please Read and sign **Section B**)  **Section A**   |  |  | | --- | --- | | I confirm I do not take Controlled Drugs / Drugs of Addiction | | | Print Name |  | | Signature |  | | Date |  |   **Section B**  **If you ticked Yes please read and sign below**  Hazelvalley Family Practice clinicians will only prescribe these drugs on a needs basis and your use will be regularly reviewed.  If you declare that you are using controlled drugs please be aware that we have a strictly adhered to policy in respect of the prescribing of controlled drugs.  If you state you are taking any controlled drugs you will be seen by a GP.  At this meeting you will be informed that as a patient of this practice you will be expected to attend regular appointments and where possible you will be weaned off these prescription drugs.  Any prescriptions issued during this period will be prescribed strictly on a weekly basis for you to collect in person.  It will be your choice as to whether you accept this agreement or choose to register with another GP practice.  If you do not declare on registration that you are taking controlled drugs and then ask for a prescription you will be removed from the patient list and advised to register with another GP practice. There are no exceptions to this rule.  Please sign below that you understand and are willing to comply with this agreement   |  |  | | --- | --- | | I confirm I understand and am willing to comply with this agreement | | | Print Name |  | | Signature |  | | Date |  | |