Dear New Patient

***Welcome to Bulkington Surgery and thank you for choosing to register with us.***

Our surgery exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website – [www.bulkingtonsurgery.com](http://www.bulkingtonsurgery.com) and social media sites.

We would ask that you complete our New Patient Questionnaire **fully** as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background and your specific needs. Please also provide the following:

* **Photographic proof of ID** (e.g. passport or a UK photo driving licence)
* **Proof of residency** (e.g. current utility bill, recent bank statement)
* **NHS NUMBER** (will show on repeat prescription or available from previous surgery)

 **Please note your registration cannot be accepted until fully completed**

We require all requested details and proof of ID and residency can be confirmed. All information provided is treated in the strictestconfidence.We would also ask that you return to the surgery a week after registering with us for an appointment with our nurse for a New Patient Check to enable us to complete your registration fully.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional within the next 48hours. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. **Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you.** You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants. You will be registered with a specific doctor who is your ‘allocated GP’ but you are able to see any doctor at the practice when available.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact the senior receptionist or the practice manager who will be pleased to help in any way to resolve the problem. The surgery operates a complaints policy details of which are on our website or ask. Also we have a ‘Friends and Family’ survey form and box in the waiting room for your feedback.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. Patients who find using the surgery difficult for whatever reason are urged to discuss this with our senior receptionist who will try to accommodate your concerns and requests.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

**ZERO TOLERANCE**

Our practice staff are here to help you. Our aim is to be as polite and helpful as possible to all patients. If you consider that you have been treated unfairly or inappropriately, please contact the practice manager, who will be happy to address your concerns.

However we strongly support the NHS policy on zero tolerance.

Anyone attending the surgery who abuses the GPs, staff or other patients be it verbally, physically or in any threatening manner whatsoever, will risk removal from the practice list. In extreme cases we may summon the police to remove offenders from the practice premises.

 **‘Care.Data’**This is a service developed by NHS England.  Confidential information from your medical records will be extracted and used by those planning NHS services or carrying our medical research, using information from different parts of the NHS.  This information along with your postcode and NHS number (but not your name) is sent to a secure system where it can be linked with other health information from other services.  This will happen automatically unless you opt-out.  If you are happy for your information to be used in this way you do not have to do anything.  If you have concerns or wish to prevent this from happening please use the opt-out form below and hand /post it into the surgery.

More information can be found here:

<http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/care-data.aspx>

<http://www.patient.co.uk/health/caredata-sharing-your-information>

[http://](http://www.patient.co.uk/health/caredata-sharing-your-information)[www.nhs.uk/caredata](http://www.nhs.uk/caredata)

**Please complete the following forms in full with the option of also signing up for online services such as booking appointments and ordering medications.**

|  |
| --- |
| **Medical History**: |
| Please list all current or past illnesses/operations including dates where possible:  |
| [ ]  Heart Disease / Angina | [ ]  Diabetes | [ ]  Epilepsy |
| [ ]  High Blood Pressure | [ ]  Stroke/TIA | [ ]  COPD |
| [ ]  Asthma | [ ]  Cancer | [ ]  Hypothyroidism |
| [ ]  Osteoporosis | [ ]  Rheumatoid Arthritis | [ ]  Dementia |
| [ ]  High Cholesterol | [ ]  Other (please state): |
| **Do you have any Allergies?**(e.g. antibiotics, food, bee sting, latex,) | [ ]  Yes | [ ]  No |
| If Yes please state: |  |
| **Immunisations;** If known, please circle the immunisation received and complete the date if known; |
|  | Date Received |  | Date Received |
| Pneumococcal |  | Tetanus |  |
| If you have a complicated medical history it would be really useful if you could obtain a copy of your electronic records from your previous practice so we have details for you for our records quickly. If you can do this by asking your previous practice and let us have the printouts as soon as possible please. |
| **Ladies:** Are you currently Pregnant?  | [ ]  Yes | [ ]  No |
| If you are pregnant please provide estimated delivery date: |  |
| **Health Information**: |
| Weight (st\lbs or Kgs) |  | Height (ft\” or metres) |  |
| **Smoking Status**: (please tick one box only) **(For help to stop smoking speak to our nurses or visit www.nhs.uk/smokefree)** |
| [ ]  I am a Smoker **Please state approx how many per day:** |
| [ ]  I have never smoked | [ ]  I am an ex-smoker - **Date quit**: |
| **Drinking:**  |
| **Number of Alcohol units consumed per week;** |  |
| Please complete the following questions (Alcohol ‘FAST’ screening test)**Screening test declined** [ ]  |
| PLEASE CIRCLE THE STATEMENT WHICH IS MOST TRUE1 drink= ½ pint of beer or 1 SMALL glass of wine or 1 single spirit |
| How often do you have:8 drinks if you are a Men6 drinks if you are a 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/clinician been concerned about your drinking/advised you to cut down? | Never | On one occasion | On more than one occasion |  |  |  |
| **Current Medication**: |
| If you have a repeat medication slip from your previous GP please attach to this form. |
| **Practice Services\Groups**: |
| **Carers**: If you are a Carer would you like to be added to the Practice’s register to receive invites for flu vacs and health checks  | [ ]  Yes | [ ]  No |
| (If yes) I care for (name): |  |
| Relationship to you: |  |
| The person I care for has: | [ ]  Dementia | [ ]  Physical Disability | [ ]  Mental Illness | [ ]  Chronic Disease |

|  |
| --- |
| **Other information\Patient Confirmation**: |
| **Care.Data:** Please see information on reverse of first page.[ ]  I wish to opt out of full data sharing with the HSCIC[ ]  I wish to opt out of the care.data programme (this means your data will not leave the practice) |
| **Electronic Prescription Service:** The practice can now send your prescription to your preferred pharmacy electronically (so no need to come into surgery to collect prescriptions). Please visit the pharmacy of your choice and register with them. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy or prescriptions will continue to go there. |
| I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice (copy online or ask)
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 | 🞏 |

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| If any of the details on this form change in the future please inform us.In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs.By completing and signing this form you are also agreeing to abide by the details of Bulkington Surgeries Patient Contract and Zero tolerance Policy (see attached appendix for infomation). |
| Signed: |  |
| Date: |  |
| Should you require any further information about the Practice please refer to the Practice Information on NHS Choices Website or speak to Reception. |
|  |
| Bulkington Surgery wants to get better at communication with our patients.  We want to make sure you can read and understand the information we send to you. If you find it hard to read our letters or if you need support at appointments please let us know how we can support you by ticking the relevant boxes below:- |
| * I need written information in Braille
 |
| * I need written information in large, clear print
 |
| * I need written information sent to me via email- because:
 |
| * I use a British Sign Language Interpreter or Advocate
 |
| * I need staff to be aware that I lip read
 |
| * I need staff to be aware that I use a hearing aid and to use the hearing loop
 |
| * I need information in another language Please state:
 |
| **Reception Only**: | **Checked postcode on website yes/ no** |
| Type of ID Seen: | 1. 2.
 |
| Seen by (initial and surname): | Name:  |
| Verbally Invited to New Patient Screen with NURSE – not GP(Patients with lots of medications or illnesses)? |  🞏 YES and Appointment booked 🞏 YES Will Book Apt Later |
|  🞏 YES but patient has Refused to Attend |



