**Stable Fold Surgery**

**NEW PATIENT QUESTIONNAIRE**

**Please complete this form and return it to Reception. After completion of this form please arrange a new patient check with the nurse, this can be done at Reception.**



**Title:**

**First Name:**

**Surname:**

**Date of Birth:**

**Occupation:**

**Address:**

**Postcode:**

**Preferred Telephone number:**

**Alternate telephone number:**

**🞏** *Please tick this box to consent to being sent text messages from the practice*

**Email:**

**Ethnicity:** (please tick)

[ ] White-British [ ] Irish

[ ] Black-Caribbean [ ] African

[ ] Asian-Indian [ ] Pakistani

[ ] Mixed-White/Asian [ ] White/Caribbean

[ ] White/African

**Other** (please specify):

**What is your height**?

**What is your weight?**

**What is your first language**?

**Do you need an interpreter**? [ ]  Yes [ ] No

**Are you registered disabled?** (if yes please give details)

**Are you allergic to any medicines and if so, which?**

**Do you have any communication needs**?

**Do you need a format other than standard print?**

**Do you have any special communication requirements?**

**How do you prefer to be contacted?:**

[ ] Telephone

[ ] Email

[ ] SMS

[ ] Letter

**Which of the following best describes how you think of yourself?**

[ ] Female (including trans women)

[ ] Male (including trans men)

[ ] Non-binary

**Is your gender identity the same as the gender you were given at** **birth?** [ ] Yes[ ] No

**Which of the following best describes you?**

[ ] Bisexual

[ ] Gay/Lesbian

[ ] Heterosexual/Straight [ ] Prefer not to say

**SMOKING**

Are you:

[ ] A smoker –how much smoked daily

[ ] An Ex smoker-when did you stop

[ ] Never smoked

**ARMED FORCES**

Have you ever served in any of the following British Armed Forces:

[ ] Army

[ ] Navy

[ ] Other

If Yes, when did you leave

**FAMILY HISTORY (FH)**

Please state any family illness of the following and also state your **relationship** to the individual.

 **Relationship**

[ ] **FH Asthma**

[ ] **FH Cancer**

[ ] **FH Heart Disease**

[ ] **FH Stroke**

[ ] **FH High Blood Pressure**

[ ] **FH Diabetes**

[ ] **FH other**

**CARERS**

Do you have you have a carer?

[ ] No [ ] Yes (If yes please give details)

**Are you a carer** for a family member, friend or neighbour who is elderly, ill or has a disability?

[ ] Yes [ ] No

Do they come to this GP practice? [ ] Yes[ ] No

Name of the person you care for:

DOB of the person you care for:

**NEXT OF KIN**

Please give the name, address and telephone number of next of kin

**Electronic Prescription Service**

Your prescription can now be sent electronically from your GP to your pharmacy.

This service is ideal for patients on stable, repeat medications, who use the same pharmacy to collect their prescription all of the time.

To sign up, please complete the attached nomination form.

The next time you require a prescription, you should order in the same way but there should be no need to come into the practice, as it will be sent electronically to the pharmacy.

To find out more about the service visit www.hscic.gov.uk/epspatients, pick up a leaflet from reception or please speak to the staff at your pharmacy or GP practice.

**EPS Nomination Consent Form**

Name:

D.O.B

Address:

Preferred Telephone number:

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 to select a particular nomination and that I can change my mind at a later date.

**Name & Address of nominated dispenser:**

**ALCOHOL SCREENING AUDIT C** (For over 15 years only)

(Scores 5+ to see a doctor)

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **SCORING SYSTEM** | **YOUR SCORE** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink that contains alcohol? | NEVER | MONTHLY OR LESS | 2-4 TIMES PER MONTH | 2-3 TIMES PER WEEK | 4+TIMES PER WEEK |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | NEVER | LESS THAN MONTHLY | MONTHLY | WEEKLY | DAILY OR ALMOST DAILY |  |

Following new government guidelines the health trainer is currently seeing patients to discuss their alcohol intake, would you be interested in this service? [ ] **Yes** [ ] **No**

***SUMMARY CARE RECORD***

**Summary Care Record – your emergency care summary**

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

**Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.**

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

[ ]  **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

[ ]  **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our GP practice staff, visit the website ([**http://www.bolton.nhs.uk/your-health/carerecords/nhs-care-records**](http://www.bolton.nhs.uk/your-health/carerecords/nhs-care-records)) or [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk)or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

DRS HALL & JACOB

**SUMMARY CARE RECORD AND INFORMATION**

[ ] Tick this box to confirm you have received an information pack about the summary care record service and wish to have a summary care record created for you.

Patient Signature:

Date:

**SUMMARY CARE RECORD OPT-OUT FORM-** Request for my clinical information to be withheld from the Summary Care Record

**If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice**

**Please complete in BLOCK CAPITALS**

**Title: Surname:**

**Forename(s**):

**Address:**

**Postcode:**

**Preferred Phone No:**

**Date of birth:**

**NHS Number** (if known:

**Signature:**

B**. If you are filling out this form on behalf of another person** or a child, their GP practice will consider this request.

Please ensure you fill out their details in section A and your details in section B

**Your name**:

**Your signature:**

**Relationship to the patient**:

**Date**:

**Consent for SystmOnline Patient Access**

At Stable Fold we offer our patients online access to book appointments for the doctor, order their repeat prescriptions and view your GP medical record online to look at your medical history, past and current medication and your allergies. If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up and operate the service. By signing this form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way. Photographic I.D. must be provided, you will then be given an access code and password to log into our website.

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name(s)** |  |
| **Date of Birth** |  |
| **NHS Number** |  |
| **Address** |  |
| **Telephone Number** |  |
| **Mobile Number** |  |
| **Email\*** |  |

**\*** If this email account is shared with others, please consider whether you agree that it can be used to send you confidential information about your account/services used.

**To be signed at Reception by patient**

**Date:**

I wish to have access to the following online services (please tick all that apply):

|  |  |  |
| --- | --- | --- |
| 1. | Booking appointments |  |
| 2. | Requesting repeat prescriptions |  |
| 3. | Limited access to parts of my medical record |  |

**Declaration (*please tick response as appropriate*)**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| 1. I agree to my GP Practice giving me access to my record online. |  |  |
| 2. I have read and understood the patient guide about online access to medical records and test results. |  |  |
| 3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the Practice. If not access may be withdrawn. |  |  |
| 4. If I see information which does not relate to me, I will immediately log out and report the matter to the Practice as soon as possible. |  |  |
| 5. I agree that it is my responsibility to keep my username and password secure. If I think these have been shared inappropriately, I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record. |  |  |
| 6. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved. |  |  |
| 7. I understand that online access is granted at the discretion of the Practice, taking into account my best interests. I will be informed of any decision not to provide access or withdraw access. Please note, this does not affect your rights of Subject Access under the Data Protection Act. |  |  |

**Other considerations**

The Practice makes every effort to record information as accurately as possible, however, there may be information that you do not feel is correct.

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| 1. If I notice any inaccuracies with my record, I will inform the Practice as soon as possible of any errors or omissions. |  |  |
| 2. I understand that I may see information on my record that I was unaware of or have forgotten about that could cause me distress. |  |  |
| 3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the Practice. If not access may be withdrawn. |  |  |
| 4. I understand that, as before, I will be informed by the Practice of any test results that require action. However, I understand that I may see these results online before the Practice has been able to contact me. This could be while the Surgery is closed and there is no one available to discuss with me. |  |  |

Once you have completed this form, your usual GP will review your medical records. This is to check that there is no information that your GP thinks you may have forgotten about or may find distressing.

Your GP will either authorise access to your records or may, in the circumstances above, ask you to attend a consultation to discuss information in your records before authorising access.

Once access to your records has been authorised by you usual GP, we will contact you to inform you that your access has been set up.

**Please remember to keep all your account details secure.**

If you have any queries or concerns about your records or the service or wish to withdraw from the service, please ring us on 01942 813678.

**For Practice Use**

Photo I.D. Shown 🞏 Date: \_\_/\_\_/\_\_\_\_ Identity verified by

(initials) : ………………………………………………………………………..

Vouched for by: 🞏 ………………………………………………………..…..

GP authorised: Yes/No…………

Name of GP …………………….……………………..……………………

Date: ………………………………………………………………..…………

Account enabled by: …………………………………………… …

Date: ……………….…………………………………………………

Patient information: Yes/No

Date: ………………………..………………………………

**New Patient Health Check txt appointment booked with:**

**Date and time:**

***GMS1 & Booklet checked by***

***ID checked via:***

[ ] **Bus Pass**

[ ] **Passport**

[ ] **Driving Licence**

[ ] **Photo ID**

[ ] **Other**

***Please scan completed form into patient medical records***