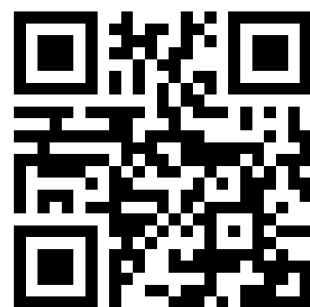


## NEW PATIENT INFORMATION AND QUESTIONNAIRE—ADULT (16+)

### 1. Information for new patients registering at the practice

- Each patient aged 16+ needs to complete this questionnaire AND a purple GMS1 form
- Help us locate your medical records by providing your NHS number and previous practice on the purple GMS1 form
- We will aim to process your registration within three days. Once it has been completed, you will get a confirmation text from us
- If you are taking regular medication, it is important that you see a doctor BEFORE you request a repeat prescription. Please make sure you have at least two weeks worth of your medications left when you register to ensure you don't run out. Our dispensary will take 5 days to prepare your prescription for collection
- Please try to return these forms between 9am and 5pm. If you visit the practice outside of these times, a member of the admin team may not be available to help you

**Want to fill in an online form instead? Visit this page to get started**



## 2. New Patient Questionnaire — Adults aged 16 and over

|      |  |               |            |
|------|--|---------------|------------|
| Name |  | Date of Birth | __/__/____ |
|------|--|---------------|------------|

Before filling in this questionnaire, please complete the **Family doctor services registration GMS1** form. If you do not have one, it can be downloaded from our website [www.freshwell.co.uk/new-patients](http://www.freshwell.co.uk/new-patients)

### Contact Details

|  |                              |                             |  |
|--|------------------------------|-----------------------------|--|
| Mobile phone number  |                              |                             |  |
| Do you consent to us leaving a voicemail on your mobile?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |  |
| Do you consent to receiving text messages from us?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |  |
| Home phone number  |                              |                             |  |
| Do you consent to us leaving a voicemail on your home phone? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |  |
| Email address  |                              |                             |  |
| Do you consent to receiving emails from us                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |  |

### Next of kin

|                          |  |
|--------------------------|--|
| Name                     |  |
| Relationship             |  |
| Emergency contact number |  |

### Communication

|   |                                  |                                |
|---|----------------------------------|--------------------------------|
| What is your main language?                                       | English <input type="checkbox"/> | Other <input type="checkbox"/> |
| If main language is not English, or is non-spoken, please specify |                                  |                                |
| Other spoken language   |                                  | Other non-spoken language      |
| Do you require an interpreter?                                    | Yes <input type="checkbox"/>     | No <input type="checkbox"/>    |
| Do you require a hearing loop?                                    | Yes <input type="checkbox"/>     | No <input type="checkbox"/>    |
| Do you require large print text?                                  | Yes <input type="checkbox"/>     | No <input type="checkbox"/>    |
| Any other communication needs?                                    |                                  |                                |

### Carer Status

|   |   |   |                             |
|---|---|---|-----------------------------|
| Are you a carer   | Yes — informal <input type="checkbox"/> | Yes — occupational <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a carer                                       | Yes — informal <input type="checkbox"/> | Yes — occupational <input type="checkbox"/> | No <input type="checkbox"/> |
| Is your carer registered at Freshwell Health Centre?      | Yes <input type="checkbox"/>            | No <input type="checkbox"/>                 |                             |
| Carer name  |   | Contact number                              |                             |
| Does your carer consent to their information being stored | Yes <input type="checkbox"/>            | No <input type="checkbox"/>                 |                             |

## Alcohol Consumption

The government require GP Practices to collect information on alcohol consumption from all newly registering patients aged 16 years or over. Please complete the first 3 questions. If you score 5 or more, please complete the additional questions. High alcohol consumption can affect you health. A member of our clinical staff might contact you to ask if you would like support or advice.

|   | Scoring System |                   |                               |                    |                           | Your Score |
|---|----------------|-------------------|-------------------------------|--------------------|---------------------------|------------|
|   | 0              | 1                 | 2                             | 3                  | 4                         |            |
| How often do you have a drink containing alcohol  | Never          | Monthly of less   | 2-4 times per month           | 2-3 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 units if male, on a single occasion in the last year                   | Never          | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| <b>Sub total—If you score 5 or more please continue with the questions below</b>  |                |                   |                               |                    |                           |            |
| How often during the last year have you found that you were not able to stop drinking once you had started?                           | Never          | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| How often during the last year have you failed to do what was expected of you because of your drinking?                               | Never          | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session | Never          | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| How often during the last year have you had a feeling of guilt or remorse after drinking?   | Never          | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| 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 or almost daily     |            |
| Have you or somebody else been injured as a result of your drinking?  | No             |                   | Yes, but not in the last year |                    | Yes, during the last year |            |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?            | No             |                   | Yes, but not in the last year |                    | Yes, during the last year |            |
| <b>Total</b>  |                |                   |                               |                    |                           |            |

| Smoking Status                       |                          |                                     |                          |
|--------------------------------------|--------------------------|-------------------------------------|--------------------------|
| I have never smoked                  | <input type="checkbox"/> | I am a current smoker               | <input type="checkbox"/> |
| I am an ex-smoker                    | <input type="checkbox"/> | and I gave up in the year           |                          |
| I have never used e-cigarettes/vaped | <input type="checkbox"/> | I am a current user of e-cigarettes | <input type="checkbox"/> |
| I am an ex-user of e-cigarettes      | <input type="checkbox"/> | and I gave up in the year           |                          |

| Height and weight   |                         |    |  |
|---|-------------------------|----|--|
| Please obtain accurate, up to date readings for this information. |                         |    |  |
| Height  | <input type="text"/> cm | or | <input type="text"/> ft and <input type="text"/> inches    |
| Weight  | <input type="text"/> kg | or | <input type="text"/> stone and <input type="text"/> pounds |
| Waist Circumference   | <input type="text"/> cm | or | <input type="text"/> ft and <input type="text"/> inches    |

| Summary Care Record – your emergency care summary   |
|---|
| <p>The NHS Summary Care Record is used in emergency care as a link to your GP medical records. To ensure those caring for you have enough information to treat you safely, the record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had.</p> <p>Your Summary Care Record is 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, the doctors treating you will have immediate access to important information about your health.</p> <p>As a patient you have a choice:</p> <ul style="list-style-type: none"> <li>⇒ <b>Yes I would like a Summary Care Record</b><br/>You can choose either the core dataset, or an enhanced one which may contain additional information</li> <li>⇒ <b>No I do not want a Summary Care Record</b></li> </ul> <p><b>You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.</b></p> <p>Additional copies of the opt out form can be collected from the GP practice, or printed from the website <a href="http://www.digital.nhs.uk/services/summary-care-records-scr">www.digital.nhs.uk/services/summary-care-records-scr</a></p> |

## Summary Care Record – continued

**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.

You can find out more by visiting these websites

⇒ [www.mse.nhs.uk/access-to-health-records](http://www.mse.nhs.uk/access-to-health-records)

⇒ [www.digital.nhs.uk/services/summary-care-records-scr](http://www.digital.nhs.uk/services/summary-care-records-scr)

If you would like more information but cannot access the internet, please call reception on 01787 461465

### Please only tick one option

YES - I would like an SCR for medication, allergies and adverse reactions only

YES - I would like an SCR for medication, allergies, adverse reactions and additional information

NO - I would not like a Summary Care Record

### Sexuality and Gender Monitoring

This section is optional but can help us provide the most relevant care to you

How would you describe your sexuality

How would you describe your gender?

Is your gender the same as you were assigned at birth?

Yes

No

If no, we may contact you to discuss which screening services are appropriate to offer you

Please tick here if you are NOT comfortable with us contacting you about screening

What are your pronouns?

He/Him/His    She/Her/Hers

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### Firearms Licence

Do you have a firearm licence?

Yes

No

Does a member of your household have a firearm licence?

Yes

No

What date was the licence issued?

### Consent to Share Information (continued on next page)

I give my consent for the surgery to share the following information:

My full record and all aspects of my care

Other information only (please specify)

**With the named person(s) below:**

|         |  |                         |  |
|---------|--|-------------------------|--|
| Name    |  | Relationship            |  |
| Address |  | Phone                   |  |
| Name    |  | Relationship to patient |  |
| Address |  | Phone                   |  |

**These instructions are valid from:**

|            |  |          |  |
|------------|--|----------|--|
| Start date |  | End date |  |
|------------|--|----------|--|

**If no end date is specified, the Surgery will accept this as a permanent instruction**

**Signature of patient for consent to share records**

|            |  |           |  |
|------------|--|-----------|--|
| Print name |  | Signature |  |
|------------|--|-----------|--|

**Online Access**

From 2nd February 2023, patients are able to see their full medical records online via the NHS app or Airmid app. You can access your account with your NHS login. If you do not have an NHS login you can create one in the app or via this website

**[www.nhsapp.service.nhs.uk/login](http://www.nhsapp.service.nhs.uk/login)**

If you cannot meet the ID requirements for an NHS login, but would still like online access, talk to our team about manually activating your online services

Some restrictions still exist about what patients can see. Records from your previous practices will show only detailed coded records, not full records.

**Practice Privacy Policy**

By completing this form you consent to certain communication pathways and supplying the practice with other information that could improve your care. All information is stored in line with our GDPR policy. Please see our practice privacy notice for patients on page 7 of this document. This information is also available in-house and on our website:

**Signature**

|            |  |           |  |
|------------|--|-----------|--|
| Print name |  | Signature |  |
|------------|--|-----------|--|

### How we use your medical records

- When we look at your medical records, we follow the laws on data protection
- Sometimes we share information about you with other people who help care for you
- Sometimes we share information about you with other people who are doing research like finding out why people get ill
- If you want to see a copy of your medical records you can
- You can object to your medical records being shared with those who help care for you.
- You can object to your medical records being used for research and other services
- If you think your medical records are wrong, you can ask for them to be corrected and you can complain to the Information Commissioner’s office.
- If you would like more information about how we use your information, you can talk to our staff, visit our website [www.freshwell.co.uk](http://www.freshwell.co.uk) or read our full privacy notice

