For staff use only – ID seen? Please detail

Pack Contents

The Riverside Practice, March Patient Registration Pack

1. Joining Instructions (this page)
2. NHS GMS1 application form
3. If you are from overseas – please ensure the "supplementary questions" on the form are completed
4. The practice New Patient Questionnaire
5. Summary Care Record Opt out form and NHS Digital Opt out details.
6. SystmOne (our Computer) sharing form
7. GDPR (General Data Protection Register) leaflet
8. Online Registration form and information (Optional)
9. Practice Leaflet (Optional

Welcome to The Riverside Practice. We all trust that your time registered with us will be a happy and healthy one. To join the practice please follow the steps described below to complete your registration.

Please note that you will not be registered at The Riverside Practice until you return all the documents to the practice. Please ensure you fill all forms, you will also need to produce TWO pieces of identification – 1 photographic and 1 proof of address.

Step 1	Complete the GMS1 form to register your details with the practice.
Step 2	Complete the New Patient Questionnaire. If you are from abroad please ensure that you complete the second side of the form
Step 3	Read the information about the Summary Care Record and decide if you wish to opt-out of this scheme. If you wish to opt-out YOU MUST complete the Summary Care Record Opt-Out form and return it with the pack. Addition information on the Summary Care Record can be found: http://www.nhscarerecords.nhs.uk/summary/ You have the right to choose whether your confidential patient information is used for research and planning. To register or to find out more visit: nhs.uk/your-nhs-data-matters The Practice Website – www.riversidepractice.com/
Step 4	Read the enclosed form "Your health record and sharing information" (Our Computer sharing form) and complete the form stating your choices.
Step 5	Return all the above pack to the Reception together with 2 pieces of identification – 1 photographic and 1 proof of address. **If you would like to obtain online registration so you can book/cancel appointments and order your medication complete the attached form.** **Your online login details will be available to collect from Reception in 3 working days.**

THE RIVERSIDE PRACTICE – NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To register with the Practice please complete this questionnaire as fully as possible and provide evidence of ID (1 photographic and 1 proof of address).

PART 1: ABOUT YOU.

Surname: Forename (s):

Date of Birth: Home telephone:

Mobile Telephone:
Please tick if you **do not want** to receive SMS Messages ☐

Email Address (In Block Capitals please)
Please tick if you **do not want** to be contacted by email ☐

Next of kin (relation to you) contact details including Address and Telephone Number

AT YOUR PREVIOUS SURGERY DID YOU HAVE A NOMINATED PHARMACY YES/NO

IF YES – PLEASE MAKE SURE THAT THIS IS STILL APPROPRIATE FOR YOU, IF NOT PLEASE REGISTER WITH A LOCAL PHARMACY.

Have you moved to England from Abroad: YES/NO
please check that the supplementary questions have been answered.

Which Ethnic group do you belong? (please tick)

White British		Asian or Asian British Bangladeshi	
White Irish		Asian or Asian British other	
White Other		Black or black British Caribbean	
Mixed white & black Caribbean		Black or black British African	
Mixed white & black African		Black or black British other	
Mixed white & black Asian		Chinese	
Mixed other		Other	
Asian or Asian British Indian		Prefer not to say	
Asian or Asian British Pakistani			

Country of birth	First spoken Language	Translator Required Yes/No

A Carer is someone who provides care on a regular and UNPAID basis for an elderly, ill or disabled relative or friend.

Are you are a carer? YES / NO

If YES, who do you care for

What is their relationship to you?

Does somebody care for you?

If so, who cares for you?

What is their relationship to you?

What is their telephone number? Daytime: Mobile:

Do you give your consent for the Practice to discuss any relevant medical information when appropriate with the above carer?

Signature: **Date:**

PART 2: ABOUT YOUR HEALTH: Please answer the following medical questions as fully as possible to help us to help you.

For Under 5s or New Babies there is no need to complete this page.

Your Weight:		Height:	
Do you Smoke?	YES / NO	Are you an ex-smoker?	YES / NO
Would you like any advice and/or treatment regarding stopping smoking?			YES / NO
Are you on any Medication? YES / NO	**(If YES please attach your latest repeat slip from your previous surgery with this completed questionnaire).**		

Alcohol Questionnaire (over 18's only) – PLEASE ANSWER ALL 10 QUESTIONS. Please tick √

Q1. How often do you have a drink containing alcohol?

Never	
Monthly or less	
2 to 4 times a month	
2 to 3 times a week	
4 or more times a week	

Q2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	
3 or 4	
5 or 6	
7 to 9	
10 or more	

Q3. How often do you have 6 or more standard drinks on one occasion?

Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

Q4. 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	

Q5. How often during the last year have you failed to do what was normally expected from you because of your drinking?

Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

Q6. 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	

Q7. 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	

Q8. 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	

Q9. Have you or someone else been injured as a result of your drinking?

No	
Yes, but not in the last year	
Yes during the last year	

Q10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No	
Yes, but not in the last year	
Yes during the last year	

PART 3.

MEDICAL HISTORY: HAVE YOU OR DO YOU SUFFER FROM ANY OF THE FOLLOWING?

Heart Disease		Stroke		Kidney Dsease	
COPD		Asthma		High Blood Pressure	
Diabetes		Epilepsy		Depression	

Female Patients Only

Hysterectomy (date if possible)		Currently taking Contraception	
Date of your last Cervical Smear			

FAMILY HISTORY: DOES YOUR FAMILY HAVE A HISTORY OF (please tick √ and state)

Heart Disease, heart attacks, angina (under 60)		Which family member?
Stroke (under 65)		Which family member?
Asthma		Which family member?
Hypertension (high blood pressure)		Which family member?
Raised Cholesterol		Which family member?
Cancer (please state type of cancer)		Which family member?
Diabetes		Which family member?
Other (please state		Which family member?

ALLERGIES – ARE YOU ALLERGIC TO ANY MEDICATION OR FOODS?

Penicillin		Nut Allergy	
Aspirin		Pollen	
Elastoplast		Bee Stings	
Latex		Wasp Stings	
Other (please specify)			

IMMUNISATIONS: PLEASE SUPPLY A RECORD OF ALL IMMUNISATIONS/VACCINATIONS TO DATE – IF POSSIBLE.
Children under the age of 5 please could you supply a list of vaccines received.

DEPENDING ON THE INFORMATION GIVEN ON THIS QUESTIONNAIRE, IT MAY BE NECESSARY FOR THE SURGERY TO CONTACT YOU TO MAKE AN APPOINTMENT WITH ONE OF OUR HEALTH CARE PROFESSIONALS.

Signature:	Date of form completion:

THIS DOCUMENT WILL BE SCANNED AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

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, the healthcare staff treating you will have immediate access to important information about your health.

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** – attached 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 the Patient Experience Team on **0800 2792535** or CAPCCG.pet@nhs.net , visit the **Cambridgeshire & Peterborough Clinical Commissioning Group website -** www.cambridgeshireandpeterboroughccg.nhs.uk, telephone the dedicated NHS Summary Care Record Information Line on **0300 123 3020**, or visit their website **www.nhscarerecords.nhs.uk**, or contact your GP practice staff.

Additional copies of the opt-out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from 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

Practice Manager

Your emergency care summary

NHS

CONFIDENTIAL

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

A. Please complete in BLOCK CAPITALS

Title .... Surname / Family name:...

Forename(s)...

Address ....

Postcode .... Phone No.. Date of birth ....

NHS Number (if known) ....

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 patient .... Date ....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- Phone the Summary Care Record Information Line on 0300 123 3020;
- Contact your local Patient Advice Liaison Service (PALS);

  or
- Contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date ....

Ref: 4705

Your health record and **sharing** of **information**

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Please read this leaflet carefully. It provides information about the choices you can make about sharing your health record. Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical details.

We use a secure electronic health records system called SystmOne. With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.

Many organisations may use SystmOne including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.

You have **two choices** which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.

Please read this leaflet and fill in your choices. You may wish to keep this section for future information. Please contact the Patient Experience Team on 0800 2792535 or CAPCCG.pet@nhs.net if you have any queries.

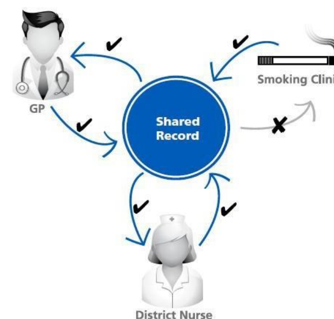
Please note: if you have previously opted out of sharing your information via the Summary Care Record, you will still need to complete this form with your choices about sharing your health record within SystmOne.

For further details visit www.cambridgeshireandpeterboroughccg.nhs.uk

Your choices at **each practice** or **service**

Sharing OUT - This controls whether your information recorded at this practice or service can be shared with other healthcare services.
Sharing IN - This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.

Imagine you're receiving care from three services: your GP, a district nurse and a smoking clinic. You want your GP and District Nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However, you don't want the smoking clinic to see any of your other medical information.



Your sharing choices at each practice or service would

be: The GP can share information IN and OUT.
The district nurse can share IN and OUT.
The smoking clinic can only share information OUT but not IN.

You can change your choices at any time. Let each practice or service know.

Note: You can request individual entries in your record to be marked as 'Private'. These are not shared with the rest of your record even if you choose to share out.

Please complete your details below and make your choices. Please complete a separate form for each of your dependents. Complete this section and return to the practice or receptionist.

PATIENT NAME: ……………………………………………… DATE OF BIRTH: …………………………………………

ADDRESS:……………………………………………………PHONE: …………………………………………………… .

…………………………………………………………………………………………….. ………………………………

SIGNATURE: ……………………………….………. DATE…………………………………………………………

The choices you would like to make about sharing your health record:

SHARING OUT **I would like my health record at this practice or service to be shared with other healthcare services providing care for me.** **YES / NO**

SHARING IN **I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services.** **YES / NO**

My choices apply to my record here at ……………………………………… PRACTICE or SERVICE

How we use your medical records

Important information for patients

- This practice handles medical records in line with laws on data protection and confidentiality.

- We share medical records with those who are involved in providing you with care and treatment.

- In some circumstances we will also share medical records for medical research, for example, to find out more about why people get ill.

- We share information when the law requires us to do so, for example, to prevent infectious diseases from spreading, or to check the care being provided to you is safe.

- You have the right to request a copy of your medical record.

- You have the right to object to your identifiable information being used for medical research and to plan health services.

- You have the right to request that any mistakes in your medical record are corrected.

- Our practice privacy notice is on the practice website which includes information on how to contact the Information Commissioner's Office to seek advice or make a complaint if you need to do so.

- For more information, please visit our website http://www.riversidepractice.com

Last Updated: May 2019