|  |  |  |
| --- | --- | --- |
| **Dr Barry A Edwards**  **Dr Sarah L Gear**  **Dr Martin J Sullivan**  **Dr Lara Mehta** | **Moss Lane Surgery**  **Madeley**  **CREWE**  **CW3 9NQ**  **Tel: (01782 750274)**  **www.madeleypractice.co.uk** | **Baldwins Gate Surgery**  **1 The Poplars**  **Tollgate Avenue**  **Baldwins Gate**  **NEWCASTLE-U-LYME**  **ST5 5DA** |

**NEWLY REGISTERING PATIENTS AGE 16 AND OVER**

Welcome to Madeley Practice

Your named GP is ………………………………………………………………………., who will have overall responsibility for your care, however you can see any doctor at the Practice.

Please make sure that you have a copy of our Practice leaflet which sets out the services we provide. If you live more than one mile from the nearest chemist you will be able to receive prescription medicines from our dispensary. Please speak to a member of the reception staff if you require further information.

**Accessible Information Standard**

We want to get better at communicating with our patients. If you have any information or communication needs we would like to find out how we can help to meet those needs.

For instance, we want to make sure you can read and understand any information we send you.

If you find it hard to read our letters or if you need someone to support you at your appointments, please let us know.

Please tell us if you need information in any other format than standard print or if you have any special communication requirements.

YOUR NEW PATIENT NURSE REVIEW APPOINTMENT

The Doctors and Nurses at Madeley Practice need to see all new patients as soon as possible after they have joined the Practice. Patients on repeat prescriptions need to be seen within one month to organise their prescription renewal. Each patient is asked to complete a health questionnaire before the appointment. When you come for the appointment you will be seen by our Health Care Support Worker or one of our Practice Nurses, who will go over the questionnaire with you and measure your weight, height and blood pressure.

You will only need to see the Doctor if you are on regular medication or have any other medical problems.

**Please make an appointment now**

Please tell the receptionist that you are a new patient so she can give you a longer appointment. Please make it clear when you make the appointment if you need to see the Doctor as well as the Practice Nurse.

Remember, all members of the family between the ages of 16 and over are invited – each will need a separate appointment. If your child is an asthmatic or diabetic under the age of 16 they will also need to have a new patient check with the Practice Nurse and Doctor.

**HEALTH QUESTIONNAIRE**

**About you**

|  |
| --- |
| Name: ………………………………….…………………… Date of Birth: ……………………………………………..  Tel number: (Home) ………………………….………. (mobile) …………………..…………….……….  Do you consent to receiving text messages from the Practice? YES / NO *(please circle)*  Occupation: ………………………...……  Are you a Military Veteran?:……………………………………..  Ethnic Group: White British / Other (please state) ………………………………………………………………………….  First Language: English Other please state …………………………..  Who is your next of kin: ….…………………………………………………….  Contact details of next of kin: …………………………………………………………………………….. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Smoking Status: | Never smoked |  | Stopped, if so when |  | Current smoker |  |

If you are a current smoker how much do you currently smoke? …………………….

**Personal Medical History:**

Have you ever suffered from or had treatment for any of the following:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma |  | Diabetes |  | Raised BP |  | Angina |  | Heart Attack |  | Stroke |  | Epilepsy |  | Cancer |  | Depression |  |

Have you any other significant medical history or ongoing treatment? …………………………………………………

………………………………………………………………………………………………………………………………………

Have you ever undergone any operations/surgical procedures? ………………………………………………………..

………………………………………………………………………………………………………………………………………

**Family History:**

Is there a family history of any conditions detailed below and if so who?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Epilepsy | Heart Attack | Diabetes | Asthma | Stroke CVA | Cancer-type | Blood pressure | Angina |
|  |  |  |  |  |  |  |  |

**Allergies**

|  |
| --- |
| Do you have any allergies? ...............................................  Have you ever had an anaesthetic problem? Yes / No  *if yes, please provide details including date and occurrence ………………………………………………………….* |

Are you a carer? Yes / No

*If yes, please provide details ……………………………………………………………………………………………….*

**COVID VACCINATION INFORMATION**

|  |  |
| --- | --- |
| **NAME** |  |
| **DATE OF BIRTH** |  |

|  |  |  |
| --- | --- | --- |
| Have you had a 1st dose of the Covid Vaccine? | YES | NO |
| **If yes** – Date given ……………………………………….  Which vaccine? *(please circle)* Astra Zeneca / Pfizer / Moderna  **If no** – please indicate whether you would like to be offered it? *(please circle)* Yes / No | | |

|  |  |  |
| --- | --- | --- |
| Have you had a 2nd dose of the Covid Vaccine? | YES | NO |
| **If yes** – Date given ……………………………………….  Which vaccine? *(please circle)* Astra Zeneca / Pfizer / Moderna  **If no** – please indicate whether you would like to be offered it? *(please circle)* Yes / No | | |
|  | | |
| Have you had a booster (third) Covid Vaccine? | YES | NO |
| **If yes** – Date given ……………………………………….  Which vaccine? *(please circle)* Pfizer / Moderna  **If no** – please indicate whether you would like to be offered it? *(please circle)* Yes / No | | |
|  | | |
| Have you had a fourth Covid Vaccine? | YES | NO |
| **If yes** – Date given ………………………………………. | | |
|  | | |
| Have you had a fifth Covid Vaccine? | YES | NO |
| **If yes** – Date given ………………………………………. | | |

**FAST**

**Fast Alcohol Screening Test**

1 unit =

½ pint of beer OR

1 glass of wine OR

1 single of spirit

**1**. **Alcohol intake units per week**

1. **MEN: How often do you have EIGHT or more drinks on one occasion?**

**WOMEN: How often do you have SIX or more drinks on one occasion?**

* 1. Never
  2. Less than monthly
  3. Monthly
  4. Weekly
  5. Daily or almost daily

**3. How often during the last year have you been unable to remember what happened the night before because of drinking?**

0 Never

1 Less than monthly

2 Monthly

3 Weekly

4 Daily or almost daily

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

0 Never

1 Less than monthly

2 Monthly

3 Weekly

4 Daily or almost daily

**5. 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?**

0 No

2 Yes on one occasion

4 Yes on more than one occasion

**The minimum score is 0, the maximum score is 16.**

**A positive response to any of the questions is predictive of an alcohol problem.**

**The score for hazardous drinking is 3 or more**



**Letter for new patients: important information about your Summary Care Record**

Dear patient,

The NHS in England has introduced the Summary Care Record, an electronic health record that can be accessed when you need urgent treatment from somebody other than your own GP.

Summary Care Records contain key information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. You will be able to add other information too if you and your GP agree that it is a good idea to do so.

If you have an accident or fall ill, the people caring for you in places like accident and emergency departments and GP out of hours services will be better equipped to treat you if they have this information. Your Summary Care Record will be available to authorised healthcare staff whenever and wherever you need treatment in England, and they will ask your permission before they look at it.

**You need to make a decision**

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

□ **Yes, I would like a Summary Care Record** *(Admin staff code: 9Ndm – express consent)*

□ **No, I do not want a Summary Care Record** *(Admin staff code: 9Ndo – express dissent)*

**Name of patient** ……………………………………………………………….

**Date of birth** ……………………………………………………………………

**Address** …………………………………………………………………………

**Signature** ……………………………………………………………………….

**If filling out this form on behalf of your child, if under 16, your name** …………………….

**Relationship to child ………………………………….. Your signature** …………………….

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 want to discuss your choices, please contact your GP practice.

You are free to change your decision at any time by informing your GP practice.

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, please tell them about Summary Care Records and explain the options available to them.

For more information talk to your GP practice, or call the Health and Social Care Information Centre on 0300 303 5678.

***----------------------------------------------------------------------------------------------------------------------------------------------***

***Admin use only:***  *CODED BY …………………………………………………….. DATE …………………………………………*

* *

NHS Summary Care Record with

Additional Information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

* Medicines you are taking
* Allergies you suffer from
* Any bad reactions to medicines

You may need to be treated by health and care professionals that 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 an SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

**You can choose** to have additional information included in your SCR, which can enhance the care you receive. This information 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
* Who should be contacted for more information about you

**What to do next**

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form, for return to the relevant GP surgery.

Name of Patient: ………………………………………………..….....................................

Date of Birth: ……………………………. Patient’s Postcode: ………………………….

Surgery Name: ………………………….. Surgery Location (Town): ……….................

NHS Number (if known): …………………………..………………....................................

Signature: …………………………………………….. Date: ……………………………….

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; **you** sign the form above and provide your details below:

Name: ………………………………………………………………………………………………

|  |  |  |
| --- | --- | --- |
| Parent | Legal Guardian | Lasting power of attorney for health and welfare |

Capacity:

*Please circle*

If you require any more information, please visit **www.hscic.gov.uk/scr/patient** phone HSCIC on **0300 303 5678** or speak to your GP Practice

**For practice use:** To update the patient’s consent status to ‘Express consent for medication, allergies, adverse reactions and Additional Information’ use the SCR consent preference dialogue box or add Read code **9Ndn** (or CTV3 code **XaXbZ** for SystmOne practices).