New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

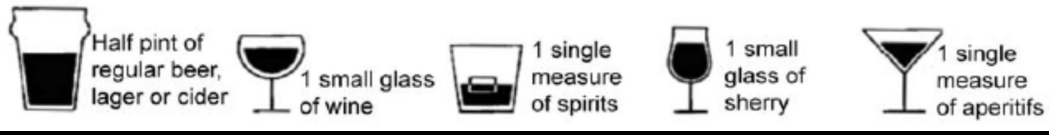
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

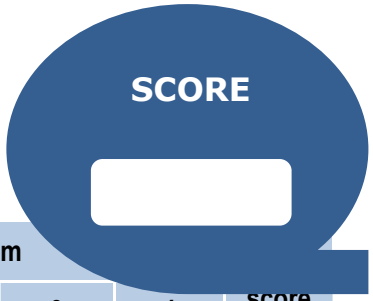


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

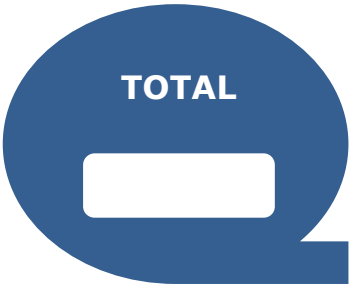


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

Named GP
I agree that upon my registration with the practice I will be allocated a named GP. I understand that I am entitled to see any other Doctor that works at the surgery.

Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

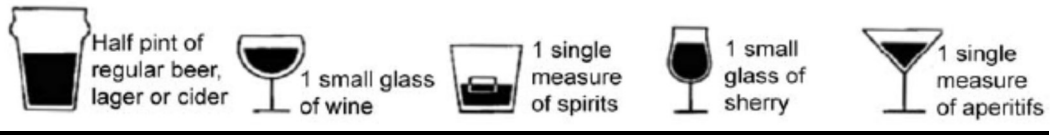
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

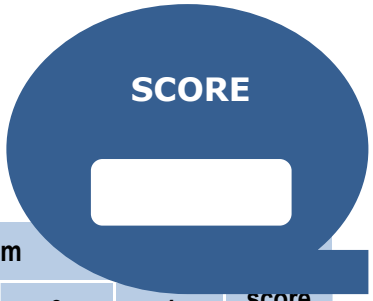


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

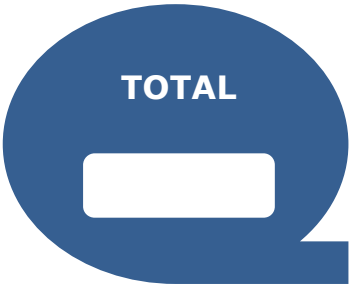


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

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☐ **Yes** ☐ **No**

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Appointments

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Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

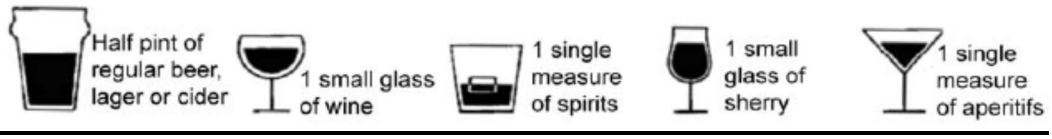
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…



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AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
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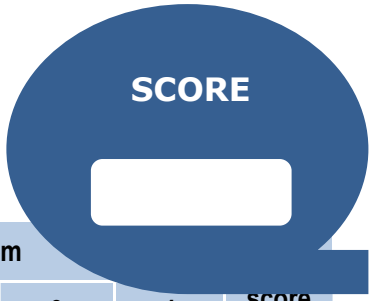

Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
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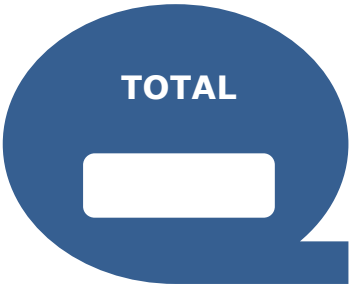

EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

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2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

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Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

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I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

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I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

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I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

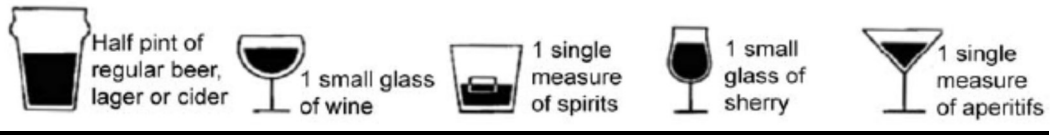
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

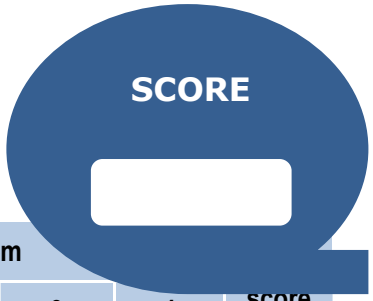


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

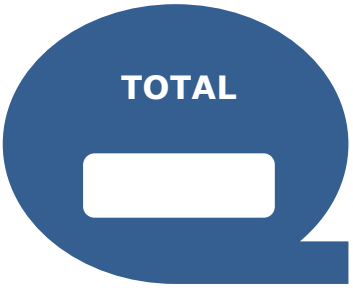


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

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DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

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Please indicate which vaccinations / immunisations you have had and the date they were given:

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MMR: ……..….. Rubella: …… Flu: ……

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Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

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CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

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Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

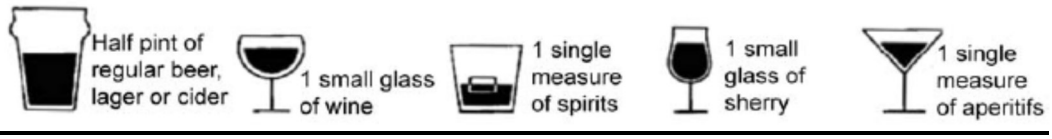
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
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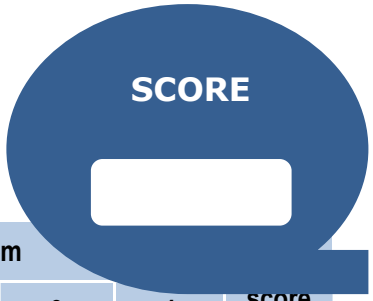

Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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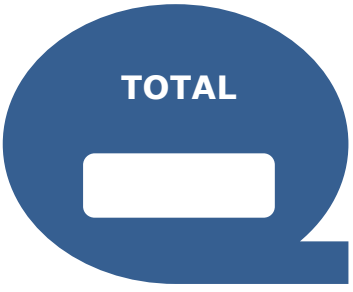

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Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

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MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

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MEDICAL HISTORY: (Please circle most relevant)

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Please tick if no allergies:

OTHER ALLERGIES:

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Date of last Cervical Smear (done in the UK): …… Result: ……

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Was the mammogram normal? YES / NO Did you require treatment? YES / NO

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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

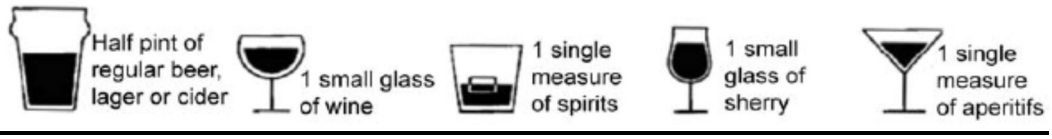
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

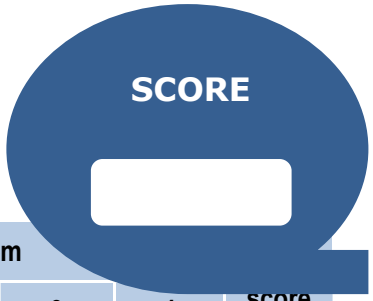


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

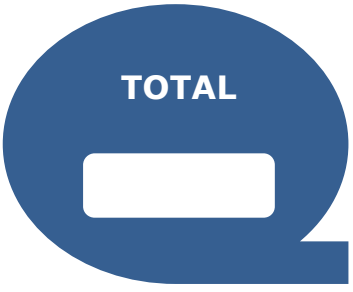


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

Named GP
I agree that upon my registration with the practice I will be allocated a named GP. I understand that I am entitled to see any other Doctor that works at the surgery.

Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

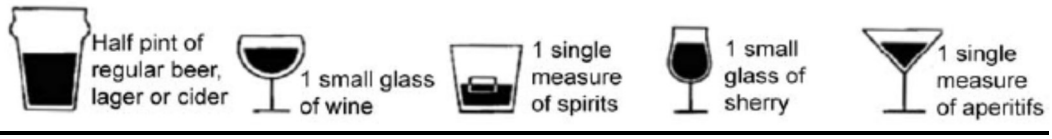
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

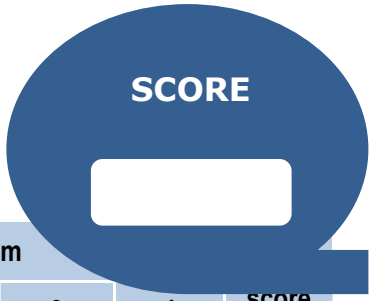


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

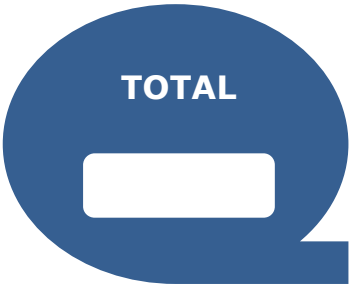


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

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☐ **Yes** ☐ **No**

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Appointments

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Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

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The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

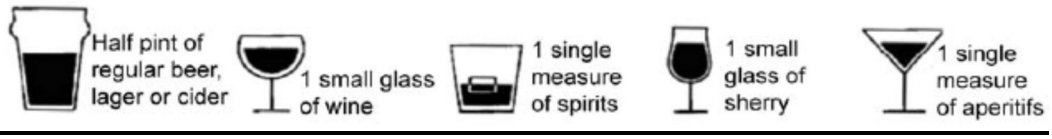
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

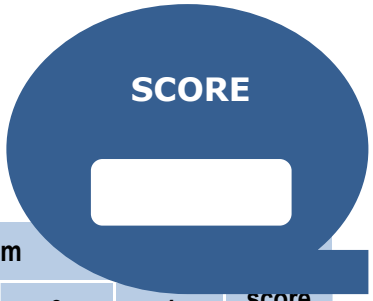


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

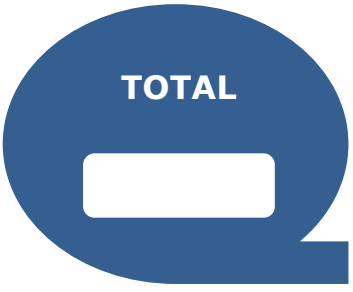


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

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We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

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Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

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I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

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I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

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Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

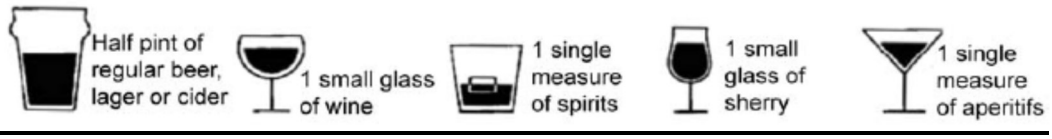
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

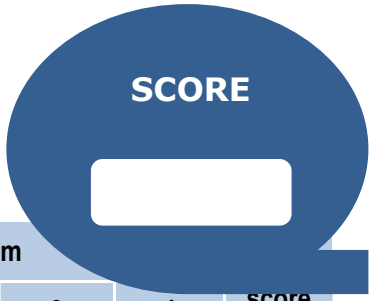


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

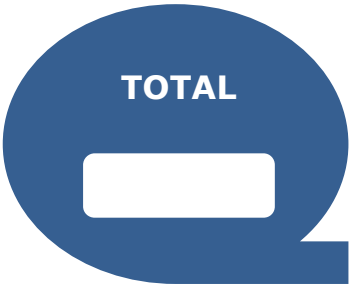


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

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MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

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Food/drink
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Telephone Consultation
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Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

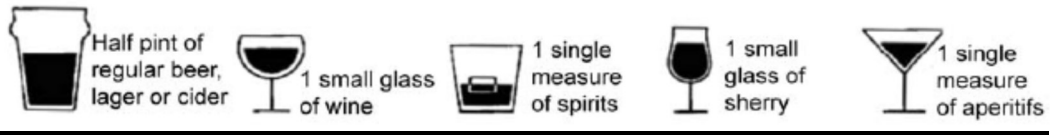
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

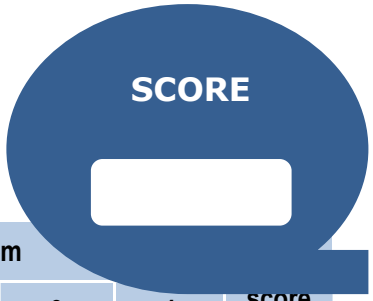


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
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TOTAL Score equals
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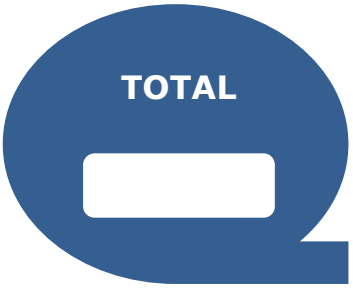

EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

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SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

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OTHER SERIOUS ILLNESS / OPERATIONS: ……

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DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

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Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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Food/drink
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The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

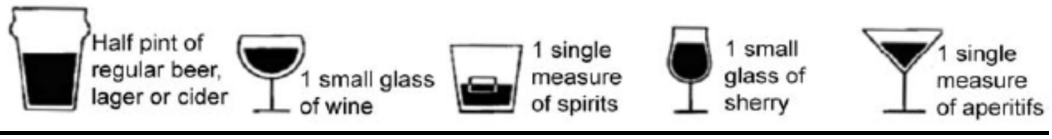
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

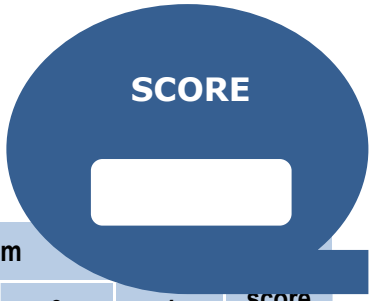


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

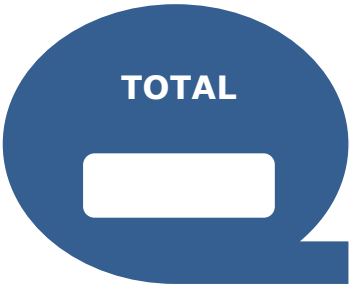


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

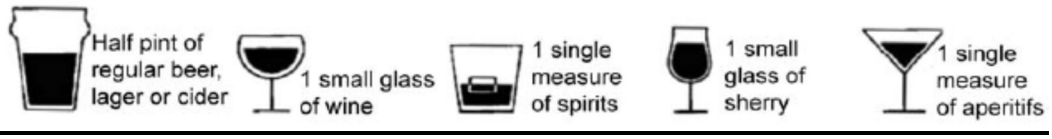
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

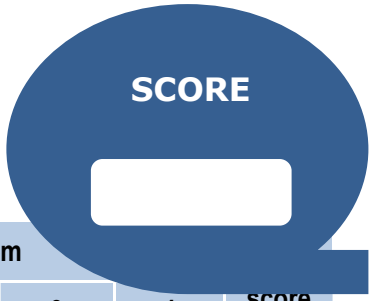


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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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	

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TOTAL Score equals
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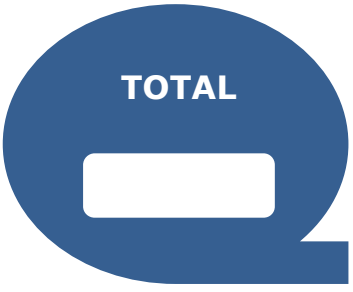

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Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

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OTHER SERIOUS ILLNESS / OPERATIONS: ……

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DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

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IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

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MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

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PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

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Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

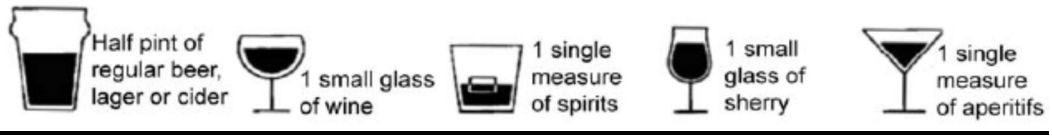
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…



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AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
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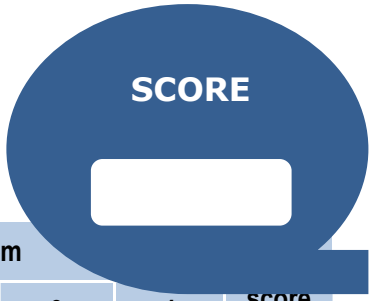

Remaining AUDIT questions

Questions	Scoring system					
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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	
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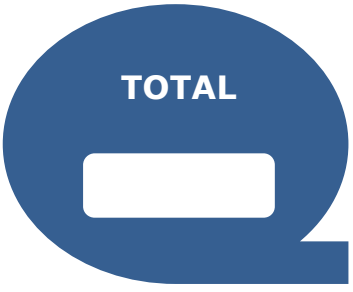
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

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☐ **Yes** ☐ **No**

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Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

Named GP
I agree that upon my registration with the practice I will be allocated a named GP. I understand that I am entitled to see any other Doctor that works at the surgery.

Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

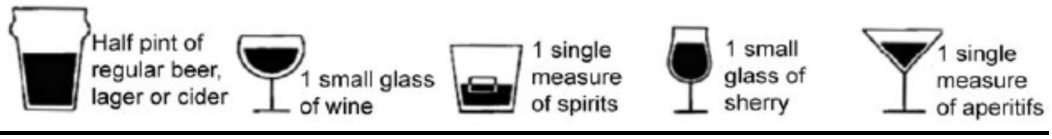
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

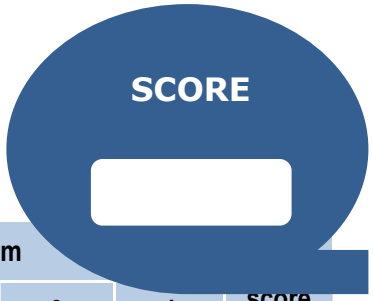


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
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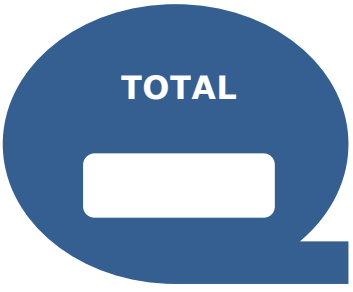
TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

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I agree to respond to Practice invitations for matters relating to my health.

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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

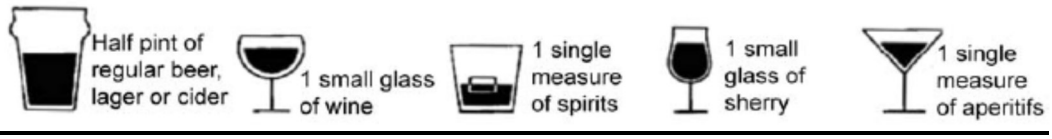
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

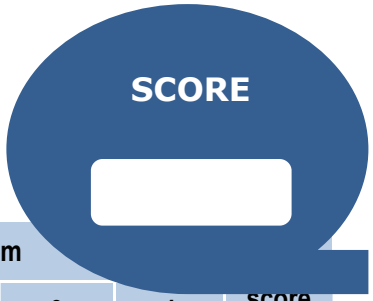


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

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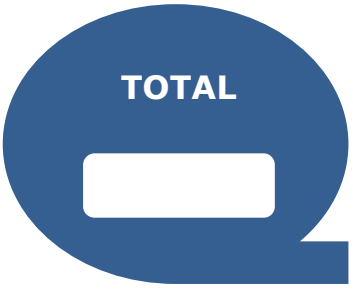

EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

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OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

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FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

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Mobile Phone

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I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

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The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

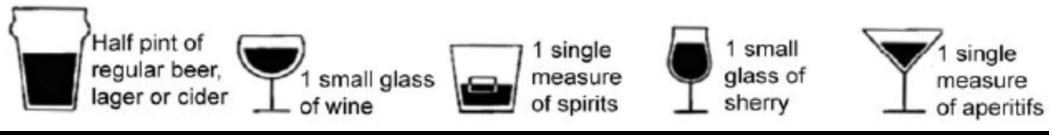
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

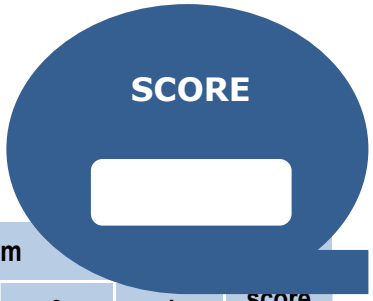


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

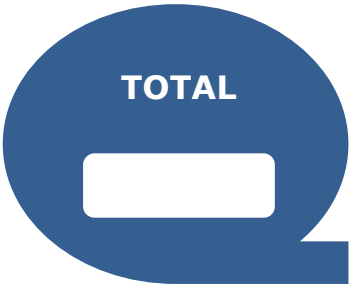


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

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I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

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Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

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Surgery Email Address lkwueke.grovesurgery@nhs.net
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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

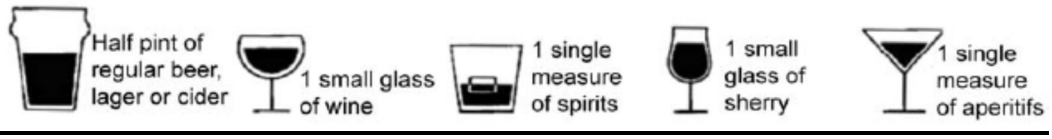
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
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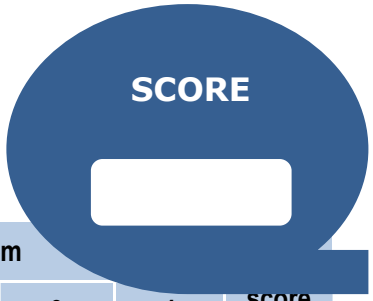

Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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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	
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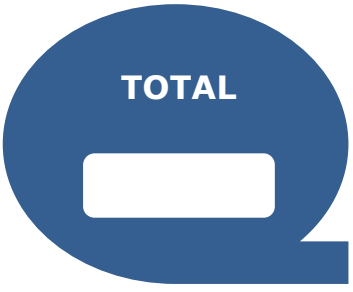

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MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

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MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

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DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

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IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

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MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
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Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

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Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

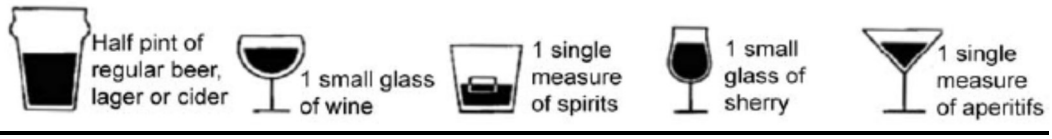
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…



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AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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+	
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Scoring:
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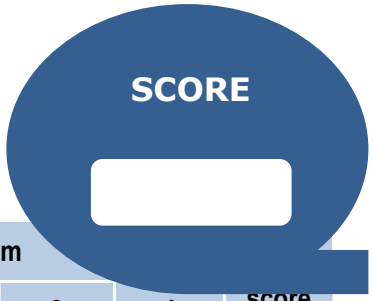
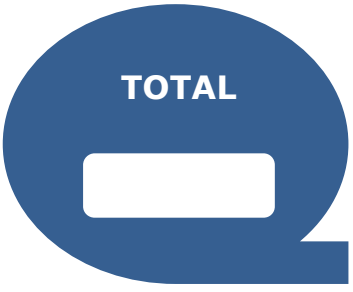


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

Emergency Calls 8am -9am (0208 800 9781)

I agree to attend emergency clinics **only** for the treatment of clinical emergencies that have occurred within the 72 hours that require immediate medical treatment. I shall not abuse this service by requesting that routine matters be considered within the emergency consultation. I agreed to call to request for emergency between 8am and 9am on the day.

Sick notes & Medical certificates

I agree that I will not ask to book an emergency appointment for receiving a sick note or a medical certificate. I understand that it is my duty to book appointments ahead of time.

Home Visits

I shall only request a home visit from the practice under circumstances that I am house bound or where I cannot physically attend at the practice; I will endeavour to make this request no later than 10:30AM.

Mobile Phone

I agree to the switch off my mobile phone before entering the practice and to keep it switched off at all the time while I am within the practice building. If I forget to switch it off before entering the practice building I agree to switch it off **immediately should it ring** while I am within the building.

Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

Named GP
I agree that upon my registration with the practice I will be allocated a named GP. I understand that I am entitled to see any other Doctor that works at the surgery.

Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

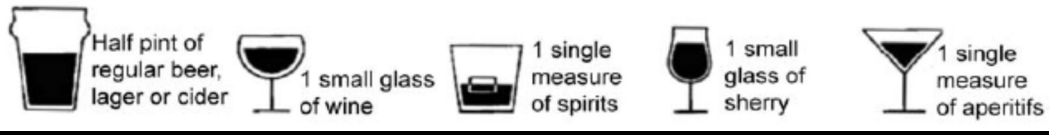
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

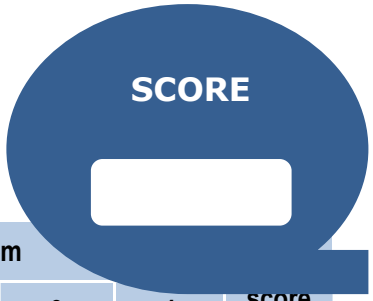


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

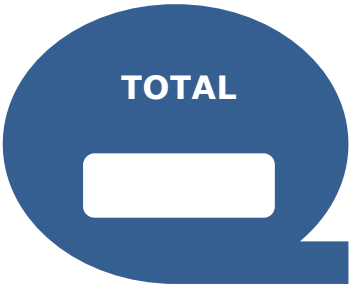


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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Mobile Phone

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Telephone result

I appreciate that I can telephone for test results and I agree to phone between the hours of 12pm and 2:00pm.

Repeat prescription

I agree to request repeat prescriptions giving the practice **48 hours notice** of my need for medication to be ready. Furthermore, I agree to make my request either in person, post or via the patient online access function. I acknowledge that request **cannot be made by telephone.**

Food/drink
I agree that in the interest of fellow patients it is unacceptable to consume food/drink within the practice building and I agree to observe this requirement at all times.

Telephone Consultation
Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

Change of Address
I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

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I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

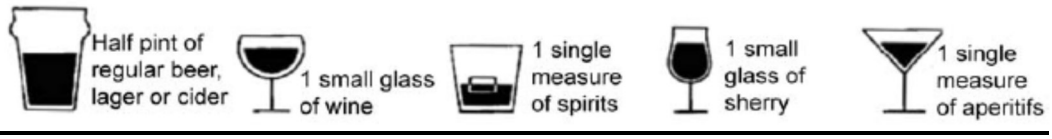
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

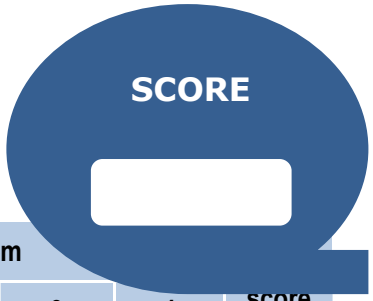


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
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TOTAL Score equals
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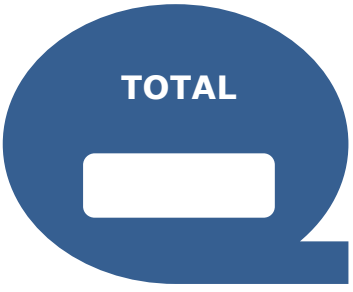

EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
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Under this agreement it is your right to be informed that the doctors can also offer telephone consultations and advice.

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I agree to inform the practice of and change of circumstance including updating my address, telephone number and e-mail address.

Surgery Email Address lkwueke.grovesurgery@nhs.net
I agree to make better use of the surgery e-mail address for updating my address, telephone number and e-mail address.

Responding to Letters and Invitations
I agree to respond to Practice invitations for matters relating to my health.

Treatment of staff
I agree with the policy of zero tolerance of abuse toward all NHS staff and I agree **not** to behave in an abusive, threatening or otherwise aggressive manner with any member of the Practice Staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner prohibited.

Named GP
I agree that upon my registration with the practice I will be allocated a named GP. I understand that I am entitled to see any other Doctor that works at the surgery.

Catchment Area (If this applies to you)
I am aware that because I live very outside of practice area the doctors will not visit me in any case of emergency if I require a home visit.

The practice thank you for signing this agreement

Practice Stamp:

Patient's name: ……

Signature: ……

Date: ……

New Patient Questionnaire

Admin staff only

Proof of address and ID seen Yes / No

Staff initial

Signature

New patients only

IMPORTANT: FILL UP EVERY AREA OF THE FORM, IF THE FORM IS INCOMPLETE WE WILL GIVE IT BACK AND ALSO MEASURE YOUR BP, HEIGHT AND WEIGHT AT THE SURGERY.

PATIENT DETAILS:

SURNAME: ……..……. **FIRST NAME(S):** ……..……..……

DATE OF BIRTH: ……..…….. **NHS NUMBER:** ……

EMAIL ADDRESS: ……

ETHNICITY: (Please circle or write in most appropriate)

A: **WHITE** British Irish Any other white background ……

B: **MIXED** White / Black Caribbean White / Black African White / Asian
Any other mixed background: ……

C: **ASIAN or ASIAN BRITISH** Indian Pakistani Bangladeshi
Any other Asian background: ……

D: **BLACK or BLACK BRITISH** Caribbean African
Any other Black background: ……

E: **NOT STATED** Not stated

DO YOU NEED AN INTERPRETER? YES/NO ……

IF YES WHAT LANGUAGE? ……..

MARITAL STATUS: ……

EMERGENCY CONTACT NAME: ……

EMERGENCY CONTACT NUMBER: ……

DO YOU LOOK AFTER SOMEONE? YES / NO……

DO YOU WISH TO BE REFERRED TO SOCIAL SERVICES TO RECEIVE INFORMATION ABOUT BENEFITS FOR CARERS? YES / NO

HOW MANY CHILDREN DO YOU HAVE? .....

MEASURE **YOUR BP AT THE SURGERY**

LIFESTYLE: (please circle most relevant)

SMOKING STATUS:

Smoker Ex-smoker Never smoked

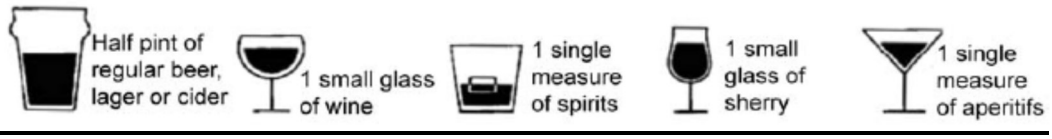
NUMBER OF CIGARETTES PER DAY .....

SMOKING ADVICE:

Smoking cessation advice Referral to stop smoking Clinic health education

MEASURE YOUR BP AT THE SURGERY HEIGHT AND WEIGHT

This is one unit of alcohol…

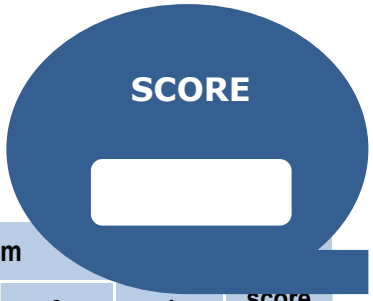


…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

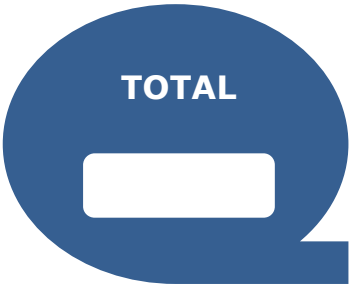


Remaining AUDIT questions

Questions	Scoring system					
	0	1	2	3	4	score
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 normally expected from 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



EXERCISE STATUS:

Enjoys light exercise Enjoys moderate exercise Enjoys heavy exercise

Takes inadequate exercise Exercise physically impossible

MEASURE YOUR BP,HEIGHT AND WEIGHT AT THE SURGERY

SEXUAL HEALTH LIFESTYLE:

Active Non Active

MEDICAL HISTORY: (Please circle most relevant)

DRUG ALLERGIES: ……. ……

……

Please tick if no allergies:

OTHER ALLERGIES:

Food Allergy Animal Allergy Other (unspecified allergy): ……..……

OTHER SERIOUS ILLNESS / OPERATIONS: ……

……

DO YOU HAVE A DISABILITY? YES / NO

CURRENT MEDICATION: Please note any repeat medication would require the patient to be seen by the practice GP before it can be prescribed.

Please list any medication you are currently taking: ……

……

……

IMMUNISATIONS / VACCINATIONS:

Please indicate which vaccinations / immunisations you have had and the date they were given:

Polio: …… Tetanus: …… BCG: ……..……

MMR: ……..….. Rubella: …… Flu: ……

Pneumococcal: …… Hepatitis B: ...……..

Other: ……..

FAMILY HISTORY: (Please state WHICH member of your family has which condition, ie. mother, father, sister, brother)

Asthma: ……..…….. CVA / TIA / Stroke: ……..……..

CHD: …… Cancer: ……

Diabetes: …… Epilepsy: ……

Hypertension: …… Other: ….……

FEMALE ONLY:

Date of last Cervical Smear (done in the UK): …… Result: ……

Are you taking any contraceptives? YES / NO Please state which type: ……

Have you had a mammogram? YES / NO Date of mammogram: ……..

Was the mammogram normal? YES / NO Did you require treatment? YES / NO

New Summary Care Record Preferences			**Effective on the content of a patient's SCR when these preferences/codes are activated**	**Put a tick as required**
Wording on SCR patient consent preference management screen	Read Code	Code term		
Express consent for medication, allergies for adverse reactions only	**Yes (9Ndm)**	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.	

Would you like to have online access? This will allow you to request your prescriptions online and see your medical records.

If you are interested please tick the box so that we can give you the access as soon as we register you.

☐ **Yes** ☐ **No**

Would you like to have a say in how we run our services?

Our **Patient Participation Group** is made out of patients and practice staff who meet once every three months. The group discusses the way the practice is run and what can be done to improve our service.

There are two ways in which you can **get involved**

1. Simply **come at the meeting**, the dates and times are displayed in the reception area

OR

2. Join the group by ticking the box below and we will contact you regarding our next PPG meeting.

☐ I agree that the practice uses my information in order to keep me informed of the next PPG meetings.

☐ I don't agree that the practice uses my information in order to keep me informed of the next PPG meetings.

If you are **undecided** on whether you want to join the PPG or not please keep in mind that you can always request the PPG joining form from the reception staff

"MEASURE YOUR BP AT THE SURGERY AND HEIGHT AND WEIGHT!!!"

Patient/Practice Agreement

Disclosure

I, the patient named below, agree to disclose all material facts regarding my heath to my General Practitioner and his/her clinical staff. We the Practice declare that we shall not disclose any information regarding the Patient without the Patient's written consent.

Confidentiality

We, the Practice, declare that we shall hold confidential all matters pertaining to the Patient and not release such information without the Patient's written consent. I, the patient named below agree that I can be contacted in regards to my health by the surgery or secondary care and aware that my information will only be stored for as long as it is necessary.

Appointments

I the patient agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I am aware that after 2 consecutive DNAs, the Practice has right to take further action.

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