**SHEVINGTON SURGERY**

**NEW PATIENT REGISTRATION PACK**

**NEW REGISTRATION PACK CONTENTS**

Each new patient registration pack contains the following:

* NHS GMS1 FORM – to be completed by the patient.
* SHEVINGTON SURGERY NEW PATIENT REGISTRATION FORM – to be completed by the patient.
* iPLATO TEXT MESSAGING SERVICE FORM – To be completed by the patient if they wish to receive appointment reminders via text message.
* Patient Online: Registration form – Access to GP Online Services.

Forms to be completed by the patient if they wish to register to view their medical records online via patient access. Two forms of Identification are required to be checked by the receptionist.

* Information on other NHS services and out of hours services.

**REGISTRATION INSTRUCTIONS**

In order to complete the registration processes please complete both the NHS GMS1 Form and SHEVINGTON SURGERY NEW PATIENT REGISTRATION FORM and return the completed forms to reception. When you attend the surgery with your completed forms, please also bring 2 forms of Identification along with you.

* **PHOTO I.D** – We will accept PASSPORT, PHOTO DRIVING LICENCE.

If you do not possess any of the above, we will accept a birth certificate or NHS Number as proof of identity.

* **PROOF OF YOUR NEW ADDRESS -** We will accept, Bank statement, Utility bill.

Upon registration, the receptionist will check your identification forms provided and check through your completed registration forms and offer you an appointment with The Nursing Assistant for a new registration health check (this is a 15-minute appointment offered to all newly registered patients). If you have any long-term medical conditions, you will be offered a 30-minute appointment with the Practice Nurse for a review.

If you are currently taking any regular repeat medication, please provide details of the medication preferably in the form of your previous copy of prescription. **You will need a medication review prior to requesting your first prescription from us, to do this please contact the surgery on 01942 483777 to book an appointment. We strongly advise that you obtain a months’ prescription from your previous surgery to give you time to get an appointment.**

**SHEVINGTON SURGERY**

**NEW PATIENT REGISTRATION FORM**

TITLE: ………………..………………………..…….………. NAME: ………………………………………..………..…………

DATE OF BIRTH: ……………………………….…….…… AGE ………………………………..………………..………………

HOME TEL NO: ………………….………..…….………… MOBILE TEL NO: …………………………………..………..…

***We have a free messaging service whereby the practice will send reminders to you regarding appointments and health campaigns via text or email.***

***Please tick the following box if you wish to opt out of this***

EMAIL ADDRESS: …………………………..…………… OCCUPATION: ………………………………..………………

HEIGHT: ………………………………..…………………… WEIGHT: ………………………………..………..….…………

NAME OF NEXT OF KIN: ……………………………… RELATIONSHIP: ..………………………………..………….

NEXT OF KIN CONTACT TELEPHONE NUMBER: …………………………………………………………….…………...

NEXT OF KIN ADDRESS: ...…………………………………………………………………………

Please provide the names and dates of births of any children that you have under the age of 19

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

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

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

Have you ever been in foster care as a child: Yes No

(If yes please give details of dates and carers): ………………………………………………………………………………..……..

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

Woman (including trans woman) ☐ Man (including trans man) ☐ non-binary ☐

In another way (pleases state): ………………………………………………….

Is your gender identity the same as the one you were given at birth? Yes/ No

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

Gay/Lesbian (2015891000006101) ☐ Bisexual (2015901000006102) ☐

Heterosexual/Straight (2015881000006104 ☐ In another way (pleases state): ☐

Decline to answer (2015931000006105) ☐

**FAMILY HISTORY**

**Have any relations had any of the following conditions?**

**(Please tick the conditions that apply and provide further details)**

HEART DISEASE Family member …………… Age of onset …………

STROKE Family member ……………. Age of onset …………

DIABETES Family member ……………. Age of onset …………

**ETHNIC ORIGIN**

**This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.**

**Choose ONE section from A to D, and then tick ONE box to indicate your background.**

|  |  |  |
| --- | --- | --- |
| 1. White |  | British (315236000) |
|  | Irish (315237009) |
|  | Any other white background, please state: (976691000000100) |
| 1. Mixed |  | White and Black Caribbean (976711000000103) |
|  | White and Black African (976731000000106) |
|  | White and Asian (976751000000104) |
|  | Any other mixed background, please state: (976771000000108) |
| 1. Asian or Asian British |  | Indian (976791000000107) |
|  | Pakistani (976811000000108) |
|  | Bangladeshi (976831000000100) |
|  | Chinese (976851000000107) |
|  | Any other Asian background, please state: (976871000000103) |
| 1. Black or Black British |  | Caribbean (976911000000101) |
|  | African (976891000000104) |
|  | Any other black background, please state: (976931000000109) |

What is your first language? ……………………………………………………………………………………….………………………

Can you speak English? Yes/No

Do you require a translator? Yes/No

Are you an Asylum Seeker? Yes/No (390790000)

Are you a Refugee? Yes/No (446654005)

**MEDICATION**

**IMPORTANT INFORMATION:**

**If you are currently taking any regular medication, we strongly advise that you try to obtain a months’ supply of medication from your previous GP before registering at a new practice. Please provide details in the form of a copy of your prescription or patient summary from your previous GP Surgery. We will also require you to have an initial appointment with a GP for a medication review/assessment before we will be able to issue your first prescription.**

**If you are currently taking any contraceptive or HRT medication, please make an appointment to see the treatment room nurse before requesting a prescription for such items. We advise that you try and book an appointment 2-4 weeks before your prescription runs out. You will need to do this every time you need a new supply.**

ARE YOU ON REGULAR MEDICATION INCLUDING CONTRACEPTION/ HRT?

Yes/No If yes please give details: ……………………………….…………………………………………..……….

**YOUR MEDICAL HISTORY**

**DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick to all that apply)**

|  |  |
| --- | --- |
| HEART DISEASE / STROKE | THYROID DISEASE |
| RHEUMATOID ARTHRITIS | DIABETES |
| HYPERTENSION | ASTHMA/COPD |
| KIDNEY DISEASE | EPILESPY |
| MENTAL HEALTH | LEARNING DISABILITY |

**IF YOU HAVE ANY OF THE ABOVE MEDICAL CONDITIONS, PLEASE MAKE AN APPOINTMENT TO SEE THE NURSING ASSISTANT FOR A NEW REGISTRATION CHECK.**

DO YOU SMOKE? Yes/No

If yes, how many: Cigarettes daily? …………… Tobacco …………oz per week.

If no, are you an ex-smoker? Yes/No

If yes, what date did you stop smoking? ………………………………………………………

DO YOU DRINK ALCOHOL? Yes/No

If yes, how many units per week? …………………………………………………………………

DO YOU HAVE A PHYSICAL OR LEARNING DISABILITY? Yes/No

IF YES (Please give details) ………………………………………………………………………………………………….…………...……….

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

DO YOU HAVE ANY LANGUAGE BARRIERS OR COMMUNICATION NEEDS? Yes/No

IF YES, please give details if you require an interpreter, sign language interpreter or if you require information in large print or braille.

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

DO YOU HAVE A CARER? Yes/No

If yes, please make an appointment with the nursing assistant for a new registration check to provide further details

ARE YOU A CARER? Yes/No

If yes, please make an appointment with the nursing assistant for a new registration check to provide further details.

ARE YOU A MILITARY VETERAN? Yes/No

If yes, please give details e.g., army, navy, RAF, reserve forces: ………………………………………………………………….

ARE YOU A FAMILY MEMBER OF A MILITARY VETERAN? Yes/No

Relationship …………………………………………………………………………………………………………………………………..…………

**NAMED GP**

**PLEASE NOTE – Whilst you will be allocated a named GP at the practice you may choose to see whichever doctor you wish.**

**TO BE COMPLETED FOR CHILDREN UNDER 19 ONLY**

PLEASE PROVIDE THE NAME, ADDRESSE AND CONTACT DETAILS OF BOTH YOUR MOTHER AND FATHER AND ANYONE ELSE WITH PARENTAL RESPONSIBILITY:

MOTHER’S NAME: ……………………………………………………………………………………………………………………………………

MOTHER’S ADDRESS: ……………………………………………………………………………………………………….……………………….

DOES MOTHER HAVE PARENTAL RESPONSIBILITY: Yes/No

MOTHER’S TELEPHONE NUMBER: …………………………………………………………………………………………………..…………

FATHER’S NAME: ………………………………………………………………………………………………….………….…….…………………

FATHER’S ADDRESS …………………………………………………………………………..……………………………….…….……………….

DOES FATHER HAVE PARENTAL RESPONSIBILITY: Yes/No

FATHER’S TELEPHONE NUMBER …………………………………………………………………………………..………….………………..

DETAILS OF ANY OTHER ADULTS WITH PARENTAL RESPONSIBILITY:

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

DETAILS OF ANY OTHER ADULTS WHO LIVE IN THE SAME HOUSEHOLD:

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

PLEASE PROVIDE THE NAME AND ADDRESS OF YOUR SCHOOL

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

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

IF YOU ARE A LOOKED AFTER CHILD, PLEASE GIVE NAMES OF YOUR FOSTER CARERS, OR YOUR CARE HOME MANAGER AND YOUR SOCIAL WORKER AND CONTACT DETAILS

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

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

Patient Access Application Form

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

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

|  |  |
| --- | --- |
| 1. Requesting repeat prescriptions |  |
| 2. Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. If I suspect that my account has been accessed by someone without my  agreement, I will contact the practice as soon as possible |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will  contact the practice as soon as possible |  |
| 6. If I think that I may come under pressure to give access to someone else  unwillingly I will contact the practice as soon as possible. |  |

Date

Signature

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method  Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled  All  Prospective  Retrospective  Detailed coded record    Limited parts  | | Notes / explanation | |

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies, and adverse reactions only.** You wish to share information about medication, allergies, and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions, and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations, and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

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

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies, and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions, and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

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

Address: ……………………………………………………………………………………………………………………..…………………………….

Postcode: ……………….………………………………… Date of Birth: ………...............................................

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

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

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

Name: …………..................................................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

**FOR USE OF STAFF ONLY:**

**Checklist – TO BE COMPLETED AT THE TIME REGISTRATION FORM IS RECEIVED**

|  |  |
| --- | --- |
| **Item** | **Completed by** |
| Medication details received in the form of prescription from previous GP if on any regular repeat medication? |  |
| *If answered yes – patient to book appointment for medication review* |  |
| *If answered no - advise patient to contact current GP practice to request a further month’s supply of medication.*  *ask patient to let us have details of any medication they are taking.* |  |
| Patient advised to ring and book a medication review in before their next supply of medication is due. |  |
| Patient allocated and informed of named GP |  |
| Patients photo ID checked and verified |  |
| Patient proof of address checked and verified |  |
| Pharmacy nomination |  |
| Appointment booked with HCA for new registration check  *(please document ‘declined’ in the completed box if patient declines appt)* |  |

**Checklist – TO BE COMPLETED WHEN PATIENTS’ REGISTRATION IS ADDED TO OUR SYSTEM**

|  |  |
| --- | --- |
| **Item** | **Completed by** |
| Details of any children under 19 added to record |  |
| If aged under 19 - details of parents, parental responsibility, carers, school etc. added to record |  |
| Patient task sent to usual GP & safeguarding lead if patient is a looked after child? |  |
| Major alert added to patients record if patient is a looked after child? |  |
| If aged under 5 - task sent to Dr Carver (safeguarding lead) to inform the health visitor |  |
| Alert added to records for any communication needs and read code added to template.  Code: 288579009 |  |
| If patient has a Learning Disability – task sent to practice nurses to check that the patient is under the care of the learning disability team |  |
| If Military Veteran code and alert added to records  Code: 753651000000107 |  |
| Family member of military veteran coded, and alert added to records.  Code: 852071000000103 |  |
| Ethnic origin/asylum seeker/refugee coded |  |
| Any household/family members are linked to records in registration |  |
| Contact information added to records and verified |  |
| Summary care Record consent preference to be recorded from the completed form |  |

**Information regarding medication for patients registering with the practice.**

If you or any person you are registering with our practice are taking any medications, (including contraceptive medication), please be advised of the following practice policies and recommendations that are in place to ensure the safety of patients.

**To ensure you have enough medications to last you during the registration/transition process, we highly recommend that all patients ensure they request a full month’s supply of their medication from their previous surgery prior to registering with our surgery.**

We need to have access to some of your medical information before we can provide any prescriptions for you. **We therefore ask that all patients who are taking medications ask their previous surgery for a brief summary and list of medications and bring this information in along with the rest of your completed registration pack.** We will also need the name and address of your previous surgery in case the doctors need any further information.

**Please be aware that all newly registered patients on medication will need to ring the surgery and book a Telephone consultation with a GP before being able to request any repeat medication.**

**We are not able to do prescriptions on the same day that you present for registration.** It can sometimes take around one to two weeks for us to be able to register you therefore you need to book a Medication Review with a GP before you get your first prescription so please ensure you have enough medication from your previous surgery.

It is also recommended that you NOMINATE a local pharmacy for any repeat prescriptions you may need, the prescriptions would then be sent electronically directly to your preferred pharmacy.

**We offer on-line ordering of prescriptions via patient access, and we would recommend that you sign up to use this on-line service as detailed on the enclosed Patient On-line Registration Form.**

**Feeling unwell?**

**Choose the right service ...**

**Walk-in-Centre**

For suspected fractures or sprains

**Sexual Health**

Spectrum sexual health service

**01942 483188**

**Pharmacy**

For minor ailments like coughs, colds, hay fever and diarrhoea

**Healthy Routes**

Weight loss, stopping smoking and alcohol support

**01942 489012**

**NHS 111**

Unsure? Confused? Need help?

Call **111** weekdays after 6.30pm or anytime during weekends and bank holidays

**Only go to A&E if you have a serious illness:**

Blacking out / bleeding you can’t stop / severe chest pain / choking / loss of consciousness / stroke

**These are all emergencies, and you need urgent hospital care!**

**Leigh Walk-in-Centre**

7am to 9pm **01942 483453** (X-rays available)

**Skelmersdale Walk-in-Centre**

8am to 7.30pm **01695 623144** (No x-ray available)

**Chorley Urgent Care Centre**

8am to 8pm **01257 261222** (x-ray available)

**A&E (Wigan Infirmary)**

For life threatening emergencies only

**Ear Care Centre**

Ear syringing service

**01942 483483**

**District Nurses**

For wound dressing / suture removal

**01942 483483**

**Mental Health**

Call the Mental Health Service 24/7 on **01942 482239** of the overnight Crisis Centre on **01942 410522**

**Podiatry (Foot Care)**

You can self-refer to Podiatry by calling

**01942 483483**

**Hub**

For additional appointments in the evenings and weekends

**01942 482848**