An appointment has been made for you to attend the surgery for you New patient registration on:

Appointment Date: …… Time: ……

Liverpool NHS

Dr S.N. Ramamoorthy & Dr M.T.N. Issa
Bigham Road
Bigham Road
Liverpool L6 6DW
Tel: 0151 263 1737
Fax: 0151 260 8307

Welcome to Bigham Road Medical Centre

You will have been given an appointment to meet our practice nurse for a new patient registration.

To ensure the smooth running of your registration, please can you bring with you:

1. **MEDICATION LIST – A PRINTED LIST FROM YOUR PREVIOUS DOCTOR (IF YOU HAVE REGULAR MEDICATION)**
2. **PROOF OF IDENTITY – IE: PASSPORT, BIRTH CERTIFICATE, DRIVING LICENCE**
3. **PROOF OF ADDRESS – PHOTOCARD DRIVING LICENCE, UTILITY BILL, BANK STATEMENT, TENANCY AGREEMENT**
4. **YOUR COMPLETED GMS1 REGISTRATION FORM (BOTH SIDES COMPLETED), PATIENT QUESTIONNAIRE, ETHNIC CATEGORY QUESTIONNAIRE, NEXT OF KIN INFORMATION, AUDIT-C QUESTIONNAIRE, PHYSICAL ACTIVITY QUESTIONNAIRE**

PLEASE NOTE–
That unless you attend for this appointment with all of the required documents, you will not be able to be registered with this practice

PROOF of I.D. Needed – Utility Bill, Tenancy Agreement, Bank Statement (not a mobile phone bill) PHOTOGRAPHIC ID passport or driving licence.

IMMEDIATE ACCESS TO YOUR GP PRACTICE
NO QUEUEING AT RECEPTION OR ON THE TELEPHONE
ANYWHERE - ANY TIME - AT YOUR CONVENIENCE
VISIT YOUR GP PRACTICE AND SIGN UP NOW

Would you like to improve access to your GP Practice and take greater control of your own health and wellbeing or that of someone you care for?

Using **Patient Online** gives you the ability to book and/or cancel appointments, order repeat prescriptions and view some of your patient record held at your GP practice, including test results, and immunisation history **24 hours per day, 7 days per week and 52 weeks of the year.**

Do you or someone you care for have a condition that requires regular medication?
YES - then you can also take advantage of the Electronic Prescription Service.
Reduce the number of times you need to contact your GP practice even more by nominating a Pharmacy of your choice to where your repeat prescriptions will be sent electronically by your GP. This can be a pharmacy near to where you live, work or shop.

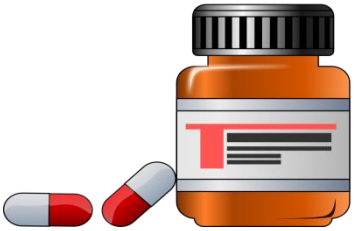
- Don't want to be held in a queue when you ring your practice to book/cancel an appointment or to ask for test results?
- Don't want to go to your GP practice every time to collect your repeat prescription.

No – Then contact your GP Practice who will explain how you can use these free of charge services or visit the website links as below:

Patient Online
https://www.england.nhs.uk/ourwork/pe/patient-online/about-the-prog/po-public/

Electronic Prescription Service
http://systems.hscic.gov.uk/eps/patients

Alternatively if you already know how to use the internet, you can take a short course on how to start using GP services online at:
http://www.learnmyway.com/what-next/health



BIGHAM ROAD MEDICAL CENTRE PATIENT QUESTIONNAIRE

Thank you for registering with the Practice, it is our policy that new patients are ONLY ACCEPTED once they have seen the Receptionist for their New Patient Registration appointment.

PERSONAL HISTORY

SURNAME **PREVIOUS NAME** **Male / Female**

FIRST NAMES **DATE OF BIRTH** **AGE**

PLACE OF BIRTH **NATIONALITY** **EMPLOYED Yes / No**

OCCUPATION **NHS NUMBER**

Address

Evidence of Permanent Residence (please give details and attach copies):

Home Tel No. **Work Tel No.** **Mobile No.**

Email address: **Consent given for communication by SMS text messaging: Yes / No**

Name, Address and Telephone number of previous doctor:

Marital status **Please circle:** **single, married, co-habiting, divorced, widow(er)**

Child(ren) living at same address – Full names and dates of birth

MEDICAL AND FAMILY HISTORY

Any present illnesses? If yes, please state.....
Any regular medication? If yes, please list here

Are you housebound: Yes / No
Have you or other family members suffered from the following: Please tick

	You	Other family membe(inc age at diagnosis & whether maternal or paternal relative)
Heart problems		
Stroke		
High blood pressure		
Diabetes		
Glaucoma		
Cancer		
Epilepsy		
Asthma		

Any known allergies – medicine

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
If "Yes", would you like them to deal with your health affairs here? Yes / No

Do you care for anyone else? Yes / No
Name of person you are caring for;

Name …….. Relationship ……

Address ……

Postcode …… Phone Number ……

SMOKING

Do you smoke? Yes / No
If Yes, how many:

Cigarettes per day …….. Cigars per day ..... Ounces of tobacco per day ……..

How old were you when you started smoking? ……..

Would you like help quitting? YES…… NO…….

You can contact FAG ENDS free or make an appointment to see our GP for treatment
FAGS ENDS phone number 0800 195 2131

EX-SMOKERS
How old were you when you stopped smoking? ……

How much did you smoke per day? ……..

PASSIVE SMOKING
Are you exposed to smoke at work? Yes / No At home? Yes / No

DIET
Do you add salt to your food after cooking? Yes / No
Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No
Has your Cholesterol been checked in the last 2 years? Yes / No

IMPORTANT NOTICE

Whilst there is a section to join the NHS Donor Register on the GMSI form, it is now your responsibility to register your details on the register.

This function was previously undertaken by the Primary Care Support Service, but due to significant staff redundancies, they are no longer able to register your details, and have as GP surgeries to undertake this task. Unfortunately, we do not have adequate administration staff to resource this either.

Should you wish to register/de-register your details on this register, you should go to www.organdonation.nhs.uk and do so on-line, or telephone 03001 232323 as this will NOT be carried out by the surgery.

We apologise for any inconvenience. *(Nov 2015)*

For Completion by GP or Practice Nurse:

Blood Pressure:

Systolic _____ Diastolic _____

Pulse _____

Height (cm) _____

Weight (kg) _____

Are you an Asylum Seeker YES/NO

LANGUAGE
What is your main spoken language? .....

RELIGION .....

INTERPRETER

Do you require an Interpreter? **Yes/No**

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

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 E, and then tick ONE box to indicate your background.

A. White	(9i0) British	( )
	(9i1) Irish	( )
	(9i2) Any other white background	( )
B. Mixed	(9i3) White and Black Caribbean	( )
	(9i4) White and Black African	( )
	(9i5) White and Asian	( )
	(9i6) Any other mixed background	( )
C. Asian or Asian British		
	(9i7) Indian	( )
	(9i8) Pakistani	( )
	(9i9) Bangladeshi	( )
	(9iA) Any other Asian background	( )
D. Black or Black British		
	(9iB) Caribbean	( )
	(9iC) African	( )
	(9iD) Any other black background	( )
E. Other Ethnic Groups		
	(9iE) Chinese	( )
	(9iF) Other ethnic category	( )
	(9iG) Not stated	( )

Main spoken language: .....

Please ask the receptionist if you need help with completing this form.

Thank you

Name:.....

Address:.....

.....

Tel No:..... Date:.....

PLEASE COMPLETE AND RETURN TO THE SURGERY AS SOON AS POSSIBLE.

NEXT OF KIN INFORMATION

Name of patient: Calling Name Surname

Date of Birth: Date of Birth

Name of next of kin 1: .....

Relationship: .....

Phone Number: .....

Address: .....

.....

Name of next of kin 2: .....

Relationship: .....

Phone Number: .....

Address: .....

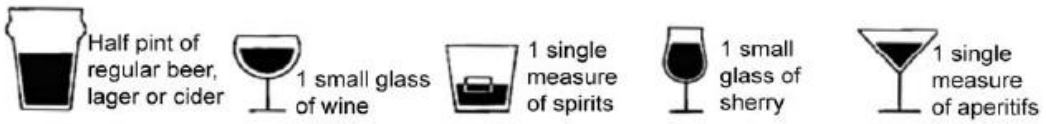
.....

Signed consent from the next of kin for the surgery to hold this information:

1: ..... Date:.....

2: ..... Date:.....

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	

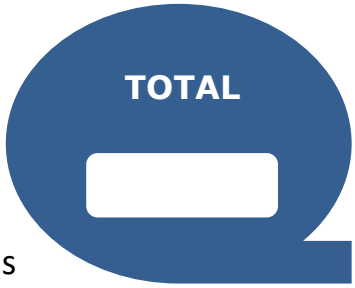
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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

General Practice Physical Activity Questionnaire

Name: ……...

During the last week, how many hours did you spend on each of the following activities?

Please mark one box only on each row

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

PLEASE PROVIDE A LIST FROM YOUR PREVIOUS SURGERY) and **bring all your medication with you for your first appointment.**

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

Name of drug: …… Dosage: ……

ALLERGIES
Are you allergic to any substances or foods? Yes / No

If yes, please give details:
……

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 who 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.

□ **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

□ **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

□ **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

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: ……..….....

Date of birth: …… Patient's postcode: ……

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

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

PRACTICE POLICY FOR
ONLINE APPOINTMENT BOOKING

Before you begin to use the online booking service, please read the following policy and attached agreement regarding the booking of appointments over the internet. Please keep this policy for your own reference.

A document containing your pin number and log-on details will be provided to you as soon as the practice receives your signed consent form. Please keep this document safe as it contains your personal information.

When registered you will be able to:

- Find available doctor appointment slots
- Book new appointments
- View appointments you have already booked
- Cancel appointments

Doctors Appointments

Please ensure that you book your appointments appropriately. If you are unsure as to whether it is appropriate for you to see a doctor, contact us by telephone. Whilst we will do what we can for you to see the doctor of your choice this may not always be possible due to unforeseen circumstances, for instance if the doctor is on sick leave or annual leave.

Missed Appointments

If you are unable to attend your appointment, please let us know as early as possible. You may cancel it online or by telephone. This will allow us to offer the appointment to another patient.

We will be monitoring missed appointments on a regular basis. If you miss an appointment more than 3 in one year we may remove the facility for you to use online booking, but you will still be able to book appointments with our receptionists.

Inappropriate use

We are sure you will find this service useful. However, your access may be revoked if you abuse the service. For your access to be reinstated, you must liaise with our reception team.

Examples of what we would consider inappropriate use are:

- Booking appointments and not using them more than [*insert number*] a year
- Booking appointments for other family members using your name.
- Consistently booking inappropriate appointments with the doctor

Appointments for Family Members:

Unfortunately, the system is not flexible enough to allow you to book appointments for family members.

Under 16s: Online booking is only available to patients aged 16 and over.

Patient Agreement to Practice Policy for the use of Online Booking

Patient Name: _____ **DoB:** _____

Address _____

_____

_____

I have understood and will adhere to the practice policy for the use of online booking. I understand that failure on my part to adhere to the policy may result in my online booking registration being terminated.

I understand that this will in no way affect my registration with the practice.

Signed _____

Date _____