Holbrooks Patient Registration 2018

Welcome to Holbrooks Health Team

Holbrooks Health Team is a large and comfortable doctors surgery, offering a range of services and clinics. It also benefits from a pharmacy on-site.

Our practice area covers Coventry, Exhall and Bedworth, if you move out of this area you will be able to continue as a patient but your registration will fall under 'special rules' and you will not be able to request home visits from the practice; this will be delivered by 111 only. Patients who are already registered with the practice but move outside this area will be re-registered under the 'special rules'. Reception will provide details on request.

In line with our contractual requirements all of our patients are allocated a named and accountable GP on registering with the practice. For those patients who are already registered you can ask Reception who you have been allocated to.

If you are registering today, your named GP is

All other information about the practice is available by collecting a practice leaflet from the waiting room or via our website http://hht-nhs.co.uk

Registering as a Patient

Once you have decided to register as a patient, all you need to do is complete the following paperwork and make an appointment to see a doctor or nurse as you need!

1. **GMS1 Registration form**. A copy is attached for your convenience; these are also available at Reception if you need several copies for family members. If you prefer to use the online service, please go to http://hht-nhs.co.uk/register.php
2. **Ethnicity form.** This information is particularly useful if English is not your first language and you need an Interpreter to be present when you see a doctor or nurse.
3. **New Patient Health Information form**. This is also attached and may be copied as you need. This allows us to register you with some basic health and lifestyle information before you see a doctor or nurse. It will also help us set up any repeat medication you are taking.
4. **Vision Online Services (VOS).** This form allows you to register for online access to Appointments, Repeat Prescriptions and a Basic Health Summary Record. This is only available to you once you have successfully registered as a patient. If you chosen not to do this at the same time, you can ask at Reception at any time in the future.
5. **FAST.** This form allows us to record your level of alcohol intake and helps us to provide appropriate advice to you.
6. **Shared Care Opt Out form.** This form allows you to prevent information about you being shared or used for purposes other than providing your care.
7. **Patient Group Participation PPG.** Have you thought about influencing the decisions we make? A small group of patients meet regularly to discuss agenda items such as Events, Campaigns, What's New, where the practice is going and provide a patient perspective to support decisions the practice needs to make. Sometimes we may invite a representative to join us at Area Team, CCG (clinical commissioning group) or even CQC (Care Quality Commission) meetings/inspections. If you do not wish to actively join the group but wish to be kept appraised of the group's activities please let us know!

STAFF ID:

GMS1 Registration form

Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✓ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

Version 01/02

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.
Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

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Ethnicity form

Ethnic Groups			
White UK (Eng/Wel/Sco/Iri)		Indian	
White (other)		Pakistani	
Chinese		Bangladeshi	
Black African		Vietnamese	
Black Caribbean		Ethnic group (refused)	
Black (other)		Ethnic group (not collected)	
Written Language			
English		Bengali	
Polish		Punjabi	
Pushto		Hindi	
Urdo		Vietnamese	
Gujerati		Creole	
Cantonese		Written Language (refused)	
Sylheti		Written Language (not collected)	
Preferred Spoken Language			
English		Bengali	
Polish		Punjabi	
Pushto		Hindi	
Urdo		Vietnamese	
Gujerati		Creole	
Cantonese		Written Language (refused)	
Sylheti		Written Language (not collected)	
Religion			
Islam		Christianity (CoE)	
Sikhism		Christianity (RC)	
Buddhism		Other	
Hinduism		Religion (refused)	
Judaism		Religion (not collected)	

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TODAY'S DATE IS:

New Patient Health Information form

Please complete as many questions as you can: the information will be confidential and will help us provide you with good medical care while we wait for your medical records to be sent from your previous doctor. **You can hand this form into Reception once completed**.

Surname ______________________

Forename(s) ______________________

Date of Birth ______________________ Mobile number ______________________

Home Telephone Number ______________________

Address ______________________

____

Post Code ______________________

Smoking

☐ I have never smoked

☐ I used to smoke Date gave up ______________________

☐ I currently smoke

☐ Cigarettes ☐ Oz of pipe tobacco

☐ Cigars ☐ Oz of roll-up tobacco

Allergies

Drug Allergies ______________________

Food/Other Allergies ______________________

Family History

Have you got a family history of the following conditions? Please state relationship to you. o you suffer, or have you ever suffered from any of the following conditions

	Stroke		Diabetes
	Angina		High Blood Pressure
	Kidney Disease		High Cholesterol
	Heart Disease		

Women Only

Date of your last cervical smear? ______________________

Type of contraception used? ______________________

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Vision Online Services (VOS)

Vision Online - Patient registration form

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password.

Patient details	Please complete in BLOCK CAPITALS
Patient forename	
Patient surname	
Date of birth	D D / M M / Y Y Y Y
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	D D / M M / Y Y Y Y
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	D D / M M / Y Y Y Y

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	D D / M M / Y Y Y Y

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FAST

Questions	Scoring system					Your score
	0	**1**	**2**	**3**	**4**	
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	
Only answer the following questions if the answer above is Monthly (1) or Less than monthly (2). Stop here if the answer is Never (0), Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

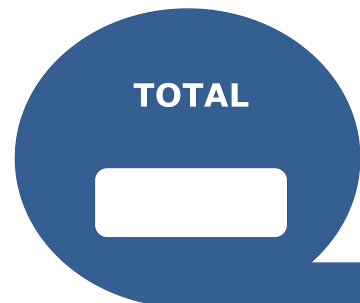
Scoring:
A score of 0 on the first question indicates FAST negative
A total of 1 – 2 on the first question then continue with the next three questions.
A total of 3 – 4 on the first question stop screening at first question.
An overall total score of 3 or above is FAST positive.

Score from FAST (other side)

Remaining AUDIT questions

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 - 8	10+	
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 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	
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	

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



hscic Health & Social Care Information Centre

You have the right to prevent confidential information about you from being shared or used for any purpose other than providing your care, except in special circumstances.

If you do not want information that identifies you to be shared outside your GP practice please fill out the form below and hand it to Reception.

THIS FORM IS PURELY FOR THE USE OF HOLBROOKS HEALTH TEAM PATIENTS WHO WISH TO OPT OUT OF SHARED CARE SERVICES

Name ______________________________

Address ______________________________

____

____

Postcode ______________________________

Telephone number ______________________________

I confirm I wish to opt out of shared care services and a record of this be made on my GP medical notes ☐

[you can opt back into Shared Care at any time by filling in a return to shared care form]

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Patient Group Participation PPG

Name	
Address	
Contact Phone Number	
Email	
Ethnicity	
Age	
Group Participation	Yes / No
Keep me informed only	Yes / No