ADELAIDE STREET SURGERY/HARRIS MEDICAL CENTRE

01253 620725/01253 763556

Dr Augustine - Dr Anthony - Dr Majumder

Thank you for your request to join our surgery. Please note that all new patients are asked to provide proff of identification. Please bring your identification, if you have any, with you when you return your registration forms.

Please ensure you have completed and signed all forms as this may delay your registration with the practice.

Yours Faithfully, Luan Stewart (Practice Business Manager).

PATIENT AGREEMENT

MOBILE PHONES I agree to switch off my phone before entering the building, and keep it turned off whilst in the building.	**REPEAT PRESCRIPTIONS** I agree to request my medication 2 working days before I require it. I also agree to make my request either in person, post, online or on a slip provided. **Please note we do not take requests over the telephone.**
APPOINTMENTS I agree to attend my appointment on time. I acknowledge that if I arrive late for my appointment, I may be asked to re-book. If you have more than one problem you wish to discuss please ask the receptionist for a double appointment. When booking an appointment reception staff will ask for a reason. All staff have signed a confidentiality agreement.	**EMERGENCY APPOINTMENTS** I agree to use these appointments for medical emergencies only. These are NOT to be used to request medication or fit notes. **FIT NOTES** Fit notes are at the discretion of the clinician.
HOME VISITS I shall only request a home visit from the practice under circumstances where I cannot physically attend. I understand that these requests, wherever possible will be made before 11am.	**TREATMENT OF STAFF** I agree that the surgery has a ZERO TOLERANCE of abuse towards staff. I agree not to behave in an abusive, threatening or otherwise aggressive manner with any member of practice staff. I acknowledge the right of the practice to remove me from their list without appeal.
COMPLAINTS If I am dissatisfied with the service I receive in any way from the practice I will in the first instance make a telephone complaint asking to speak to the reception supervisor.	**CHAPERONES** A chaperone is available for any consultation at any stage. This can be requested via the reception staff or any clinical staff member. I understand that the clinician also has the right to request a chaperone at any point.
BENZODIAZAPINE WITHDRAWAL POLICY I agree to sign up to a reduction programme if I am on any of these drugs e.g. diazepam, lorazepam etc. I will be requested to make an appointment to see our in-house pharmacist.	**TEXT MESSAGING SERVICE** The practice uses a text messaging service for appointment reminders and other health related matters. I acknowledge that appointment reminders are an additional service and that they may not take place on all occasions. The responsibility of attending or cancelling appointments rests with me. I can cancel the text message facility at any time.

Patient Agreement Signature

Name …….

Date of Birth ……

Signature ……………………………………………………………………………………..

Date ……………………………………………………………………………………………….

For surgery use only

Identification seen: Yes/No   Type of ID seen: ____

Checked by (print name): _______________________________________   **Date:** __________________________________

Adelaide Street Family Practice &

The Harris Medical Centre

New Patient Questionnaire Age 16+

Adelaide Street Family Practice
incorporating The Harris Medical Centre

Welcome to Adelaide Street Family Practice & Harris Medical Centre, **Members of the CENTRAL WEST PRIMARY CARE NETWORK.**

Please complete this questionnaire clearly using **BLOCK CAPITALS**. The information will be treated in strict confidence.

PERSONAL DETAILS: (It is VERY IMPORTANT that you let us know as soon as possible if any of these details change).

TITLE: [ ] Mr [ ] Mrs [ ] Ms [ ] Mx [ ] Dr [ ] Reverend [ ] Professor	
NAME:	DATE OF BIRTH:
HOME TELEPHONE:	MOBILE:
EMAIL:	

Do you live in a multi-occupancy accomodation (i.e. share bathroom/kitchen facilities with others who are not members of your household)? Yes [ ] No [ ] Flat number ____________(if applicable).

OTHER MEMBERS OF YOUR HOUSEHOLD

NAME	AGE	DATE OF BIRTH	RELATIONSHIP TO YOU

ETHNIC ORIGIN (PLEASE TICK ONE)

White (British)		Other Asian or Asian British		Mixed (White & Asian)	
White (Irish)		Chinese		Mixed (White & Black African)	
White (Other)		Black or Black British (Caribbean)		Mixed (White & Other)	
Asian or Asian British (Indian)		Black or Black British (African)		Other Ethnic Group	
Asian or Asian British (Bangladeshi)		Black or Black British (Other)		Prefer not to say	
Asian or Asian British (Pakistani)		Mixed (White & Black Caribbean)			

MAIN SPOKEN LANGUAGE (please specify): ____

Do you have any difficulty in speaking or understanding English? Yes [ ] No [ ]

How do you define your sexual orientation?

Gay man		Gay woman/Lesbian		Heterosexual/Straight	
Bisexual		Other (please state)		Unknown	
Prefer not to say					

Is your gender the same as the sex you were registered with at birth?

Yes [ ] No [ ] Prefer not to say [ ]

Preferred pronoun: he/him/his [ ] she/her/hers [ ] they/them/their [ ]

NEXT OF KIN

Title (Mr, Mrs, Ms etc.):	Name:
Address:	
Contact No:	Relationship:

If you have a carer please give their name, contact details and relationship to you:

____

If you are an unpaid carer for an elderly or frail relative or friend, please give their name and relationship to you:

____

If you have a social worker, please give their name and contact details:

____

DISABILITIES & HEALTH

Please give details of any disabilities you have (tick all that apply):

Eyesight: Blind [ ] Partially Sighted [ ] Colour-blind [ ] Other (please state) ___________________________

Are you registered blind? Yes [ ] No [ ]

Hearing: Deafness [ ] Partially Deaf [ ] Other (please state)____

Do you use a hearing aid? Yes [ ] No [ ]

Mobility: Mobility Issues [ ] Use a Wheelchair/Scooter [ ] Use a Walking Frame/Stick [ ]

No Mobility Issues [ ]

Have your **mother, father, brother** or **sister** suffered from high blood pressure, heart problems, stroke or diabetes? If so, please state which disease(s) and which family member(s).

____

____

____

____

Are you pregnant? Yes [ ] No [ ] What is your expected delivery date? _______________________________

Have you ever served in the armed forces? Yes [ ] No [ ]

If yes, which? Army [ ] Navy [ ] Air Force [ ] Marines [ ]

HOW WE COMMUNICATE WITH YOU

Do you need written information in large format? Yes [ ] No [ ]

Do you need an interpreter for sign language? Yes [ ] No [ ] Makaton/BSL?__________

Do you need an interpreter for your main spoken language? Yes [ ] No [ ]

Do you need information in EASY READ format with pictures to help you? Yes [ ] No [ ]

Tick here if you are **NOT** happy for us to send you information by Text [ ] Email [ ]

LIFESTYLE

Have you **ever** smoked tobacco? Yes [ ] No [ ]

Do you **currently** smoke tobacco? Yes [ ] No [ ] How many cigarettes per day? ________

Do other people regularly smoke near you? Yes [ ] No [ ] You may be 'passive smoking'.

Do you use electronic cigarettes? Yes [ ] No [ ]

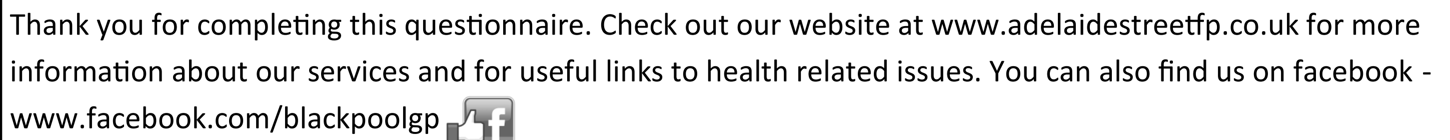
We strongly advise all smokers to quit and are happy to help. Once registered speak to reception to make an appointment with our smoking cessation nurse.

Do you drink alcohol? Yes [ ] No [ ] If so, what do you normally drink? ________________________________

If you do drink alcohol, please complete the table below.

	Score					
Questions	**0**	**1**	**2**	**3**	**4**	**Your Score**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has anyone else been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

In the last 2 weeks, how often have you been bothered by any of the following problems. Please tick the relevant boxes.	Not at all	Several days	More than half the days	Nearly every day
Little interest or please in doing things				
Feeling down, depressed or hopeless				
Trouble falling or stating asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or over eating				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Feeling bad about yourself, that you are a failure or you have let yourself or your family down				
Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety ort restless that you have been moving around more than usual.				
Thoughts that you would be better off dead, or of hurting yourself in some way.				
SURGERY USE ONLY Total Score = /27	**0**	**1**	**2**	**3**



Thank you for completing this questionnaire. Check out our website at www.adelaidestreetfp.co.uk for more information about our services and for useful links to health related issues. You can also find us on facebook - www.facebook.com/blackpoolgp

For surgery use only

Adelaide [ ] Harris [ ]

NPQ checked by: ______________________________ **Date:** ______________________________

Information for new patients: about your Summary Care Record

NHS Digital

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 to 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 your consent for medication allergies and adverse reactions only (Core SCR).**
  You wish to share information about medication, allergies and adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information (SCR with additional information)**
  You wish to share information about medication, allergies, adverse reactions and further medical information which 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 choose 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.

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

Adelaide Street Family Practice &

The Harris Medical Centre

Application to Register

Adelaide Street Family Practice
incorporating The Harris Medical Centre

Welcome to Adelaide Street Family Practice & The Harris Medical Centre, **members of the Central West Primary Care Network.**

Please check the following list and tick each item as applicable;

[ ] I have fully completed the application form and new patient questionnaire and have provided the following (if available):

Photographic identification (specify) ____

Proof of address (specify type) ____

Parental responsibility (children only) ____

[ ] I have read and understood the practice terms & conditions and agree to be bound by them. This is a condition of registration.

[ ] I nominate the following pharmacy to receive my repeat prescriptions by electronic means (should I need them). I can change this nomination at any time by informing the practice.____

[ ] I wish to be able to use online services such as booking appointments and ordering repeat prescriptions and therefore require an online account (these details will be sent to you in the post).

Summary Care Record

[ ] Yes - I consent to information about my medications, allergies and adverse reactions, illnesses and health problems, operations and vaccinations, how I would like to be treated (such as where I would prefer to receive care), what support I might need and who should be contacted for more information about me being shared across different healthcare organisations and systems that need the information to provide me with the best possible care and who work within strict NHS permissions and confidentiality rules **(Summary Care Record with additional information)**.

[ ] Yes - I consent to only information about my medications, allergies and adverse reactions but no other information being shared as above **(Core Summary Care Record)**

[ ] No - I would **not** like a Summary Care Record.

I understand that if no selection is made a core summary care record will be created and that I can change my mind at any time by informing the practice.

Signed: ……………………………………………………………… Date of birth …………………………………………..

Date: ………………………………………………………………… Print name: ……………………………………………..

SURGERY USE ONLY

Checked by: ____ **Date:** ______________________________