

**NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE (ADULT)**

**(Revised OCTOBER 2020)**

This information will remain strictly confidential. Please make sure you answer all questions and sign the form.

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| **PATIENT DETAILS**  | **PLEASE COMPLETE IN BLOCK CAPITALS** |
| TITLE: MR/MRS/MISS/MS/DR/OTHER (please state) | SURNAME: |
| FORENAMES: | DATE OF BIRTH: |
| MOBILE TELEPHONE NUMBER:You will automatically be sent a text reminder for appointments. Please tick the box if you wish to opt out of this service   |
| EMAIL:By providing an email address you agree to being contacted by the practice using this method. Please tick the box if you wish to opt out of this service   |
| Have you ever been registered with the Practice before? Yes No **If Yes, why did you leave?**  |

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| **Allergies:** Please give details of any allergies or drug sensitivities you may have. |
| **Specific Needs:** Do you have any specific needs that the Practice needs to be aware of e.g. sensory or physical disabilities, phobias, interpreter, religious or cultural requirements? (Please give details) |
| **CHOICES ABOUT SHARING YOUR INFORMATION** |
| **Summary Care Record (SCR):**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 by ticking the appropriate box: * **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.

**Oxfordshire Care Summary:**In addition to the national Summary Care Record, The Oxfordshire Care Summary will allow authorised healthcare professionals involved in your care locally, such as out of hours GPs or hospital doctors, 'view-only' access to more detailed information about your treatment and care. Instant access to reliable health information will help local health care professionals to give you safer, faster treatment.Healthcare professionals must have your permission before they view your Oxfordshire Care Summary, other than in exceptional circumstances such as if you are unconscious.An Oxfordshire Care Summary will automatically be created for you unless you opt put by ticking the box below.* **No – Express dissent for an Oxfordshire Care Record**

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. |

**Consent to authorise another person to receive medical information on your behalf.**

**Details of person to be given access to this Patient’s information:**

If you want us to be able to give information to a relative, friend or carer please complete the form below. You may authorise us to give your appointed representatives any medical information that they request or limit this to any particular area e.g. test results, as you wish.

**Details of person to be given access to this Patient’s information:**

|  |  |
| --- | --- |
| **Full name** |  |
| **Address** |  |
| **Relationship to you** |  |

(if more than one person is to be given access then please list the above details for each additional person on a separate piece of paper)

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| **Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)** |
| Space for details of any additional person if required: |

**Patient Online Services Registration Form**

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online.

**Before you apply for online access to your record, there are some other things to consider.**

**Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.**

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| **Things to consider** |
|  | **Forgotten history** There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news** If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.  |
| **Choosing to share your information with someone** It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure.  |
| **Coercion** If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information** Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.  |
| **Information about someone else** If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible |

**Patient Online Services Registration Form**

Having read the previous page, I would like to have access to the following GP online services (tick all that apply):

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| Booking appointments |  |
| Requesting repeat prescriptions |  |
| If repeat prescriptions online access requested, which chemist would you like to nominate to collect your prescriptions from:Bretts, Grove□ Cleggs, Wantage□ Boots, Wantage□Lloyds, Health Centre □ Other □ please state…………………………………..This information will be added to your notes and will be the primary chemist for you to collect your medication from. |  |
| Accessing my medical record (can only be requested if photo ID has been provided) |  |
| Sign up for SMS messaging and appointment reminders (mobile no, must be provided on the front page of this form) |  |

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

|  |  |
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| I have read and understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |  |

**Your login details will be sent to you in due course.**

**The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

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| **Information about you** |
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| What is your: |
| Height  |  |
| Weight |  |
| Do you undertake regular exercise? Yes/No |
| If yes how much and how often? |
| And what type of exercise? |

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|  |  |
| --- | --- |
| Do you currently smoke? | Yes/No |
| If yes, when did you start? |  |
| On average, how many cigarettes or ounces of tobacco do you smoke per day? |  |
| Would you like some help to stop smoking? | Yes/No |
|  |  |
| If you are a non-smoker, have you ever smoked? | Yes/No |
| If yes, when did you finally give up? |  |
| For how many years did you smoke? |  |
| On average, how many cigarettes or ounces of tobacco did you smoke per day? |  |

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| **Carers and those with carers** |
| Church Street Practice keeps a register of patients who either care for an elderly, infirm or disabled relative or friend or those patients who require the help of a relative or friend, to enable us to offer appropriate help and advice. Please tick the appropriate box. |
| I am the main carer for an elderly, infirm or disabled relative or friend. What help do you give? |  |
| I rely on the help of a friend or relative to enable me to continue living at home. What assistance do you receive?  |  |
| Name of your carer or the person you care for: |

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Do you drink alcohol? Yes/No

This is one unit of alcohol…

**2**

**2**

**3**

**3**

**9**

Half a small glass of wine

1 small glass of sherry

1 single measure of aperitifs

1 single measure of spirits

Half pint of “regular” beer, lager or cider

If Yes,

How often do you have an alcoholic drink? (circle your answer)

Never Monthly 2-4 times 2-3 times 4+ times

 or less per month per week per week

How many units of alcohol do you drink on a typical day when you are drinking? (circle your answer)

1-2 3-4 5-6 7-9 10+

How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? (circle your answer)

Never Less than Monthly Weekly Daily or

 Monthly almost daily

**Ethnicity**

 White British  White Irish  White Other  Black African  Black Caribbean

 Indian  Pakistani  Bangladeshi  Chinese  Other (please state) \_\_\_\_\_\_\_\_\_\_\_

**What is your first language?**

 English  Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WILL YOU NEED AN INTERPRETER YES/NO

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| --- |
| You are free to change your decision regarding your consent choices at any time by informing your GP practice.**SIGNATURE ……………………………………………………………DATE ……………..**Signed by Patient Signed on behalf of Patient |
| **FOR PRACTICE USE ONLY** |
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| **Registration received by** | **Date** |
| **ID Seen (if not, reason)** | **Registration data entered by** |
| **Online registration authorised** | **Date** |

**NB: If patient has been registered at practice before check reason for returning has** **been supplied.****If patient is resident in a nursing home pass to Reception/Practice Manager.** |