Adult form

DOWNLANDS MEDICAL CENTRE

Downlands Medical Centre
77 High Street
Polegate
East Sussex
BN26 6AE
Tel: 01323 482323
Fax: 01323 488497

New patient registration requirements

- Please fill out both forms given by the receptionist to the best of your ability. (Purple form and Patient questionnaire).
- Please make sure you put your NHS number on both forms, we need this to register you. (This is an 10 digit number) You can get this from your previous surgery, prescription re-order forms or hospital letters.
- Please make sure you fill out your previous address and doctor's surgery.
- When you bring the forms back to the surgery we will need 2 forms of ID. We need photo ID for example we need: Passport, Driving Licence and proof of address for example we need: Bank statement, utility bill, Council tax bill.
- Please make sure you sign both forms.
- Please bring forms back to the Polegate branch.
- Please note: It can take up to a week to get you registered on the system.
- **For patients on repeat prescriptions:** If you are signed up with a chemist near to your previous surgery, please make sure you remove yourselves from that chemist and sign up EPS (Electronic Prescribing Service) with a chemist nearby when registering with us.

DOWNLANDS MEDICAL CENTRE - POLEGATE

1. New Patient Registration – Health Questionnaire

Complete a separate form for each person

To register with the Practice please complete this questionnaire. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Each family member applying needs a separate questionnaire.

ABOUT YOU							
Title		**Surname**		**First names**			
Address					**Postcode**		
Email							
Home tel. no.				**Mobile**			
D.O.B (dd/mm/yy)		**Height**			**Weight**		
NHS number		**Occupation**			**Married Y/N?**		

FAMILY HISTORY Is there any of the following in your family (father, mother, brother, sister) before age of 65? (circle which applies and if 'YES' enter details)			
Heart Disease (heart attacks, angina)?	Yes/No	**Which family member?**	
Diabetes?	Yes/No		
Stroke? (under the age of 50 (male) 55 (female)	Yes/No		
High Blood pressure?	Yes/No		
Cancer?	Yes/No		
Cancer location?			

Ethnic Category Code (Please tick)

White A – British ☐ B – Irish ☐ C – Any other white background ☐	**Mixed** D – White and Black Caribbean ☐ E – White and Black African ☐ F – White and Asian ☐ G – Any other mixed background ☐
Asian or Asian British H – Indian ☐ J – Pakistani ☐ K – Bangladeshi ☐ L – Any other Asian background ☐	**Black or Black British** M – Caribbean ☐ N – African ☐ P – Any other black background ☐
Other Ethnic Groups R – Chinese ☐ S – Any other ethnic group ☐ Z – Not stated ☐	I do not wish to disclose ☐

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SMOKING (circle which applies and if 'YES' enter details if required)				
Do you smoke?	Yes/No	**How many cigarettes per day?**		
		How many cigars per day?		
		How many ounces of tobacco per day?		
Age started smoking				
Did you smoke?	Yes/No	**How much did you smoke per day?**		
Age you stopped				
Passive Smoking: are you exposed to smoke	**At work?**	Yes/No	**At home?**	Yes/No

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

EXERCISE (circle which applies):	
Do you take regular exercise?	Yes/No
If 'yes', what sort of exercise?	
If 'yes' how many times per week?	

PAST MEDICAL HISTORY	
Details of any hospital treatment as an in-patient	
Details of any treatment for any chronic medical conditions	
Dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound	

DOWNLANDS MEDICAL CENTRE - POLEGATE

Over 16's Alcohol Questionnaire – Please Complete Section 1

Name:……Date of birth:……Date: …..……

Audit C

1 Using the above chart, how many units do you have per week? ☐

Scoring System

Questions	0	1	2	3	4	Your Score
2 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	
3 How many standard alcoholic drinks do you have on a typical day when drinking?	1-2	3-4	5-6	7-8	10+	
4 How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scored 5 or more? – Please complete questions 5-11 (Audit)

Total (Q 2-4) ☐

Alcohol Users Disorders Identification Test (AUDIT)

Scoring System

Questions	0	1	2	3	4	Your Score
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5 How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6 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	
7 How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8 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	
9 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	
10 Has a relative/friend/doctor/ health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
11						

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

By completing this form you may be contacted by an alcohol support worke

Total (Q2-11) ☐

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IMMUNISATIONS	
Dates of Triple/polio/HIB	
Dates of MMR	
Date of last Tetanus	

NEXT OF KIN DETAILS					
	Surname		**First names**		
Address				**Postcode**	
Contact tel. no. - mobile		**Landline**			
Relationship to Patient					

FEMALE PATIENTS	
Date of most recent cervical smear & result	
If over 50 have you had a mammogram?	YES/NO Date……
Do you use contraception. If yes, what method?	YES/NO

MEDICATION

Give details of any medication which you take (prescribed or otherwise)

Please note that a repeat prescription can only be issued on receipt of a medication request slip from your previous surgery, or relevant packaging.

Name of drug	Dosage

ALLERGIES (circle which applies and if 'YES' enter details)	
Are you allergic to any substances or foods?	Yes/No
Details	

Military Veteran (UK)

Please tick here if you are currently serving, or have ever served, in the UK Armed Forces (this included reservists or part-time service, e.g.: Territorial Army) ☐

Please tick here if you are a member of a current or former serviceman or woman's immediate family/household ☐

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Carers

Are you a carer Yes ☐ No ☐ if yes, please can we have the name of the person you care for: ……..

and what is your relationship?……

'Care for the carers' are available to help you on: 01323 738390. www.cftc.org.uk

Contacting you

From time to time we may need to contact you by, telephone, text, email or post. By supplying your Email and mobile telephone number you are agreeing to be contacted by the Practice. Sometimes we may leave a message on your answer phone for you to contact us. If you have any objections to the above please inform the practice.

TEXT MESSAGING APPOINTMENT REMINDER SERVICE

We now offer a text messaging appointment reminder service.

To ensure you receive a text message reminder of any forthcoming appointments please complete and sign below:

I consent to using the text messaging service YES / NO

I accept responsibility to advise you of any change to my mobile no. YES / NO

Do you have any special communication needs? ☐ Yes ☐ No

If yes, please let us know how we can help you.

Thank you for completing this questionnaire. Please hand into reception as soon as possible.

Your doctor will assess the information provided and may invite you for an initial examination, discussion about your health, and and general check.

Acceptable forms of id = Passport or driving licence and one item confirming your current address:

Medical card
Local authority or housing association rent card/ book
Paid utility account
Bank or credit card statement

For office use only- type of identification seen ……..

DOWNLANDS MEDICAL CENTRE - POLEGATE

1.1. Summary care record opt-out form

You are entitled to request that your clinical information be withheld from the Summary Care Record and you should complete this form if you wish to do so.

What does it mean if I **do not have** a summary care record?

- NHS Healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any adverse reactions to medicines you have had, in order to treat you safely in an emergency.
- Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices:

- Phone the Summary Care Record Information Line on 0300 123 3020
- Contact your local Patient Advice Liaison Service (PALS) or
- Speak with a receptionist

If you do not want a Summary Care Record complete and sign below.

Surname		**First names**	
Address			**Postcode**
Home tel. number		**Mobile**	
D.O.B (dd/mm/yy)		**NHS number**	
Signed		**Date**	

1.2. Electronic Prescription Service

Your prescriptions can now be sent to your nominated pharmacy electronically after preparation. Please see the attached information sheet and if you want to nominate a preferred pharmacy to dispense your medications – visit the Pharmacy and sign a nomination form.

You will still need to order your regular repeat medications.

This can be done by the following methods:

- On-line after registering for this service,
- By completing the reorder form on the right hand side of your prescription / or by letter posted to us through the letter box at Polegate or Willingdon Surgeries or sent by Royal Mail.
- By completing a repeat prescription request at the reception desks at Polegate or Willingdon.
- Through your preferred Pharmacy

PLEASE NOTE WE CANNOT TAKE PRESCRIPTION REQUESTS OVER THE TELEPHONE

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Dr M P Sharp
Dr D Tennant
Dr J Jadav
Dr J Higgin
Dr I Creek
Dr R Newton

Application for Patient Online Services

Just like online banking, you can look at your GP records on a computer, a tablet or a smart phone, using a website or an app. You can choose:

Book and cancel appointment with your doctor or nurse online, when it suits you. Your surgery will choose which appointments can be booked online.

Order repeat prescriptions online. Some patients have found that they save money and time as they don't need to make a special trip to their surgery to order repeat prescriptions.

Look at part of your GP records online. You can look at your records whenever you want, even from the comfort of your home, and find answers to questions you may have without, ringing your doctor.

Surname		Date of Birth	
First Name			
Address Postcode			
Email address*			
	**Please note this email address will be used to send or reset your confidential information*		
Telephone number		Mobile number	

I wish to have the following online services *(tick):*

1. Booking appointments	
2. Requesting repeat prescriptions	
3. View summary information in GP record (medications,. Allergies, bad reactions)	

I wish to access services 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
5. If I see information in my record that is not about me or is incorrect, I will contact the practice as soon as possible	

Name		Date	
Signature			

If you wish to register for online services then please return this form completed to Downlands Medical Centre along with Photo ID to enable us to register you

Thank you

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Third Party Access and Collection

With the introduction of the new data protection law (GDPR) we are required to have your permission if you wish for a third party to collect any items (e.g. prescription, letters, blood requests) on your behalf or for a third party to discuss your medical care.

Please complete the relevant sections below detailing any third parties you wish to be able to do this on your behalf,

Please note that any third party collecting on your behalf must be able to provide ID. Young people aged 13 and above need to consent for an adult acting on their behalf.

Collection Consent

I	
Of	

Give my permission for the following people to collect items on my behalf:

Name	Relationship to patient

Signed			
Print Name		Date	

Discussion Consent

I	
Of	

Give my permission for the following people to discuss all aspects of my medical care with Downlands Medical Centre:

Name	Relationship to patient

Signed			
Print Name		Date	