**Westminster Surgery**

12-18 Church Parade

Ellesmere Port

 CH65 2ER

0151 355 4864

Welcome New Patient,

Thank you for your registration request with Westminster Surgery,

1. Firstly please complete **all** attached forms and return these to the reception desk at the surgery,

**WITH AT LEAST 2 FORMS OF IDENTIFICATION**

**(One must be photographic ID, one must contain the patient’s current address)**

1. Within the next 10 days (After completion of documentation) please contact us on **0151 355 4864** to make an appointment with the Healthcare Assistant for a **New Patient Health Check**\*

\*It is very important that you book this as if you fail to make this appointment or fail to attend, your registration will not be completed and your medical records will be sent back to the health authority.

If you are on any repeat medication, please ensure you have at least **1 months’ supply** from your previous GP surgery to allow adequate provision during the transition period of your medical records.

I have read and acknowledged this letter and understand the registration process.

Please sign and date below.

**Signed**: ................................................................................................................

**Print**: ....................................................................................................................

**Date**: ....................................................................................................................

**Terms of Conditions of Westminster Surgery**

Dear Patient,

On registration, we require consent that you abide by our terms and conditions of our practice.

Please read carefully the following terms and conditions and sign the declaration at the bottom. (a copy of this document will be kept on your medical record). Should you refuse to agree to our surgery policies we will not be able to register you as a patient at this practice.

**Violence & aggression**

We operate a zero tolerance policy towards violence and aggression. CWP deem this behaviour as unacceptable and it could result from you being removed from the practice and may even be removed from the patient list.

**Patient Access Service**

This enables a quicker and efficient service whereby you can book appointments and order prescriptions online for more convenience. You can book appointments up to 4 weeks in advance.

**To activate this service, please bring 1 form of photographic ID and we can provide you with an access code to use the patient access service.**

**Repeat Prescriptions**

All repeat prescriptions take 48 hours prior to collection. **Please note we do not accept prescription requests over the telephone.** A prescription request form is available at reception in the clinic. You can also order at the pharmacy or using our online service (please ask at reception)

**Medication not prescribed**

We have a strict prescribing policy, and there are a number of medications which we do not prescribe.

* Zopiclone
* Diazepam
* Temazepam
* Nitrazepam

If you elect to register with the surgery and are currently taking any of the above medication, you will need a GP appointment to discuss a supervised reduction and discontinuation.

**Appointments**

Appointments can be booked by telephone, in person or online (Patient Access Service). On booking appointments by telephone, the reception team will ask for a brief description on your reason to direct you to the most appropriate clinician. As we are **a very busy surgery** we are not always able to offer routine appointments at short notice. Should you suffer a genuine medical emergency we may be able to offer an emergency appointment **however, these appointments are reserved for genuine medical emergencies requiring immediate medical attention and cannot be used for reasons of convenience.**

**Home visits**

We are only able to offer home visits in **exceptional** circumstances, such as when a patient is genuinely housebound, or where a medical problem makes it impossible for a patient to be brought to the surgery. Lack of transport to attend at the surgery is not an appropriate reason for a home visit.

**Signed:** ………………………………………….. **Date:** …………………………………………………..

**New Patient Registration Form**

|  |
| --- |
| **Full name: Date of Birth:** |
|  |
| **Address:** |
|  |
| **Post code:** |
|  |
| **Telephone Number: Home: Mobile:**  |
|  |
| **Gender: Female** [ ]  **Male** [ ]  **Transgender** [ ]  **Prefer not to say** [ ]  |
|  |
| **Sexual orientation:** | **Marital status:** |
|  |
| **Religion:**  |
|  |
| **Do you agree to us using these details to contact you? Yes** [ ]  **No** [ ]  |
|  |
| **Occupation:** |
|  |
| **Do you have a disability? Yes** [ ]  **No** [ ]  |
|  |
| **Are you / Do you have a carer? Yes** [ ]  **No** [ ]  |
|  |
| **Carers details:**  |
|  |
| **Do you/or your carer have a Communication need?** **If yes how can your need be met?** |
|  |
| **Next of kin:** |
|  |
| **Female only:**  |
|  |
| **Are you currently pregnant or on maternity leave? Yes**[ ]  **No** [ ]  **prefer not to say** [ ]  |

**LIFESTYLE**

|  |
| --- |
| **Height: Weight:** |
|  |
| **Do you smoke: Yes / No :** |
| **If Yes How many a day:** |
| **If No Have you ever smoked?** |
|  |
| **Smoking cessation advice given** **[ ]**  |
|  |
| **How many glass of:**  |
|  **Wine do you drink in an average week?** |
|  **Spirits do you drink in an average week?** |
|  **Pints of Beer do you drink in an average week?** |
| **If NONE, are you completely teetotal?** |

**ELECTRONIC PRESCRIPTION SERVICE (EPS)**

**The Electronic Prescription Service (EPS) allows the GP Practice to send your prescription to the pharmacy of your choice electronically. This removes the need for you to attend at the practice one your prescription has been authorised by a GP.**

**Please indicate below which pharmacy you would like your prescriptions sending to:**

|  |  |
| --- | --- |
| PHARMACY NAME |  |
| ADDRESS |  |
| PATIENT’S NAME |  |
| SIGNED |  |
| DATE |  |

Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and Westminster would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting the practice.

Please complete this form and hand it in at the practice reception
if you consent to any, or all, of the above.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  | Date of Birth | ………./………./………. |
| Mobile |  | Consent to use? | Y | N |
| Email |  | Consent to use? | Y | N |
|  |  | Date |  |

**Ethnic Group and Language Questionnaire**

Please tick the appropriate ethnicity box and complete the first language box

|  |  |
| --- | --- |
| **Ethnic group** | Tick Here |
| **A: White*** British
 |  |
| * Irish
 |  |
| * Any other White background (please write below)
 |  |
| **B: Mixed*** White and Black Caribbean
 |  |
| * White and Black African
 |  |
| * White and Asian
 |  |
| * Any other White background (please write below)
 |  |
| **C: Asian or Asian British*** Indian
 |  |
| * Pakistani
 |  |
| * Bangladeshi
 |  |
| * Any other Asian background (please write below)
 |  |
| **D: Black or Black British*** Caribbean
 |  |
| * African
 |  |
| * Any other Black background (please write below)
 |  |
| **E: Chinese or other ethnic group*** Chinese
 |  |
| * Any other Black background (please write below)
 |  |
| **Not stated / declined*** Declined: Patient chooses not to supply this information
 |  |

|  |  |
| --- | --- |
| Please advise of your main spoken languageTranslator required | Yes/No |

**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, ifyou **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 adversereactions.

Once you have completed the consent form, please return it to your GP practice.

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



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**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: …………………

Surgery name: …………………………… Surgery location (Town): ………..................

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,](https://www.digital.nhs.uk/summary-care-records/patients) call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

|  |  |  |
| --- | --- | --- |
| **Summary Care Record consent preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (express consent for | 9Ndm. | XaXbY |
| medication, allergies and adverse reactions only) |  |  |
| The patient wants a Summary Care Record with core and additional | 9Ndn. | XaXbZ |
| information (express consent for medication, allergies, adverse reactions and |  |  |
| additional information) |  |  |
| The patient does not want to have a Summary Care Record (express dissent | 9Ndo. | XaXj6 |
| for Summary Care Record – opt out) |  |  |

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*Overview of the Cheshire Care Record*

**Sharing your health and social care information**

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**A collaboration between all GP, hospital, community, mental health and social care services provided across Cheshire.**

Whether you are visiting your GP, attending hospital, or being seen in your own home or health centre by a community nurse or social worker, we want you to get the best care.

We can only do this if all the health and social care professionals involved in your care have access to the information they need to make informed decisions with you. By sharing a summary of the information included in your health and social care records, they can provide better care.

**What is my health and social care information?**

Your shared health and social care information will include information like test results, medications, allergies and social or mental health information relevant to your care.

The professionals treating you will be able to look at computer records of the care you are receiving from other organisations, including your GP or the hospital.

This means:

* You don’t have to keep repeating your medical or social care history
* Care professionals have access to the right information when they need it
* There will be less duplicate appointments and tests
* You will receive the right treatment and care more quickly.

Timely access to your health and social care records will ensure that GPs, hospital doctors, nurses, social workers and other health and social care professionals have an overview of your care in order to make the best decisions about your diagnosis, treatment and care plan.

**Who will be able to see my shared health and social care information?**

Your information will only be accessed by health and social care professionals – such as the district nurse involved in your care – if you have given your consent. You will be asked for this consent the first time that a health or social care professional wishes to view your record. If you have already told your GP that you don’t want your health data to be shared, you may wish to reconsider and ask your GP to share your data locally so that a Cheshire Care Record can be created for you. This could be really helpful when making decisions about the care you need. Alternatively you can inform your GP at any time if you don’t want your information to be shared.

**Who are the participating organisations?**

* Cheshire GP Practices
* [NHS West Cheshire Clinical Commissioning Group](http://www.westcheshireccg.nhs.uk/)
* [Countess of Chester Hospital NHS Foundation Trust](http://www.coch.nhs.uk/)
* [The Clatterbridge Cancer Centre NHS Foundation Trust](http://www.clatterbridgecc.nhs.uk/)
* [Cheshire West and Chester Council, Social Care](http://www.cheshirewestandchester.gov.uk/residents/health_and_social_care/adultsocialcare/information_and_advice.aspx)

I have read the information and understand the benefits there are for the local health professionals in being able to view my records at a time of need and the improved care that this would enable me to receive.

Please tick **ONE** of the following:

 I **DO** wish to share my record with Local Health Professionals when required

 I **DO NOT** wish to share my record with Local Health Professionals

**Your Signature:** …………………………………………………………………..

**Date:** ………………………………………………