**The Bridge Surgery, 8 Evesham Road, Headless Cross, Redditch, B97 4LA**
**01527 555600**

# Patient Registration Pack - Bridge Surgery 2019

## New Patient Information

### IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this unfortunately we cannot accept photocopies of documents as proof of identity or address on returning your pack if you are able to please use the machine in the Front Foyer to take your height, weight and blood pressure – this does not require a chip or token it is free, stand on press the green button and follow the instructions. Then return you're the slip to reception along with your registration pack

### PROOF OF NAME
### (One of the following)

- Birth Certificate
- Marriage Certificate
- Driving Licence (valid)*
- Passport (Valid)*

### PROOF OF ADDRESS;MUST BE DATED WITHIN THE LAST 3 MONTHS
### (One of the following)

- Utility Bill
- Council Rent Book
- Bank Statement
- Credit Card Statement
- Letter from Benefits Agency

***Please note if applying for Online Access to your medical records, photo ID must be produced. Registration Form can be found on Page 10 of your registration pack**

**Information for New Patients.**
**We're improving how we communicate with patients.**
**Please tell us if you need information in a different format or need communication support.**

**OPENING TIMES**

**MONDAY – FRIDAY:**

**8:30AM – 1:00PM**

**1:00pm – 2:00pm - Closed**

**2:00PM – 6:30PM**

**PHONE LINES**

**Our phone lines open at 8.30am - 1.00pm and 2.00pm - 5.30pm**

**CONSULTING TIMES**

**Appointments with GPs and Nursing Staff are available**

**09:00 am - 12:00 pm and 3:00 pm - 5:30pm Monday to Friday**

**EXTENDED HOURS**

*** Late evening appointments are available on Mondays and Wednesdays between 18:30 and 19:30. These appointments are available but are subject to meeting certain criteria**

**WE ARE HERE FOR YOU FOR LONGER**

**Across Redditch and Bromsgrove General Practices are working together to provide further appointments with GPs and Nurses on evenings and weekends . These can be accessed via the HUB and booked through your usual practice. The Extended Access HUB is currently held at a central location and this will be St Stephens Surgery in Redditch. We will hold at least one extended access clinic each month for further details please ask at reception.**

**As part of the Extended Access Hub we are now also offering an early morning bloods clinic held a St Stephens Surgery this will be held one day a week, subject to change for further information and to book you early morning blood test please ask at reception.**

| **Personal Details** | |
|---|---|
| **Title** | |
| **Surname** | |
| **Forename** | |
| **Middle Name(s)** | |
| **Previous Surname(s) (where applicable)** | |
| **Date of Birth** | |
| **NHS Number** | |
| **Gender** | |
| **Marital Status** | |
| **Town & Country of Birth** | |
| **Are there any children registered at the above address?** | |
| **Main Language** | |
| **Interpreter Required?** | |

| **HOME ADDRESS:** | |
|---|---|
| **House Name\Flat Number** | |
| **Number & Street** | |
| **Locality** | |
| **Town** | |
| **County** | |
| **Postcode** | |

| **CONTACT DETAILS:** | |
|---|---|
| **Home Telephone** | |
| **Mobile Telephone** | |
| **Work Telephone** | |
| **Email Address** | |
| **PATIENT CONTACTS:** | |
| **Next of Kin** | |
| **Relationship** | |
| **Next of Kin Telephone Number** | |

| | |
|---|---|
| **Ethnicity** | **In order that we may take into account a patient's culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices.. Please Circle appropriate**<br><br>White British — Pakistani<br>White Irish — Bangladeshi<br>White Other background — Other Asian<br>White & Black Caribbean — Black Caribbean<br>White & Black African — Black African<br>White & Asian background — Other Black<br>Other Mixed background — Chinese<br>Indian — Any Other |
| **If Other Please Specify** | |

**PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:**

| | |
|---|---|
| **Previous address in the UK** | |

| | |
|---|---|
| **Name & Address of previous GP** | |

**Please Advise the Practice of Your Communication Preferences**:

I Would like to receive reminders for my appointments via SMS Text ☐

I Do Not wish to receive reminders for my appointments via SMS Text ☐

**Female Patients Only:**

In order that we can arrange the correct follow-up, please advise us if you are :-

Pregnant ☐ EDD .........................................................

Or have had Insertion of the Following Contraceptive devices:

IUCD (coil) ☐ Date of insertion ………………………………

Implanon/Nexplanon ☐ Date of insertion………………………………

**Assistance During Appointments**

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator ☐

Deafness – require a sign language translator ☐

Disability – require a carer ☐

**Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age?**

YES ☐ NO ☐

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for: ☐

Address : ☐

## Smoking Status

**Please tick the appropriate box:**

I have never smoked ☐

I am an ex-smoker ☐

If so when did you stop? ☐

How many a day did you smoke ☐

**I am a smoker :** ☐

**How many per day:** ☐

**Patient Information:**
If you do smoke and you are keen to give up but need some encouragement and guidance, please make an appointment to see one of our nurses.
Also please check out Smoking Quit Line Tel: 0800 00 22 00 (UK FREE PHONE) OR Website Link: www.givingupsmoking.co.uk

**Please List all your current or past illnesses/operations including dates :**

| | | | |
|---|---|---|---|
| ☐ | Heart disease/Angina | High Blood Pressure | ☐ |
| ☐ | Asthma | COPD | ☐ |
| ☐ | Diabetes | Epilepsy | ☐ |
| ☐ | Stroke/TIA | Cancer | ☐ |
| ☐ | Hypo/Hyperthyroidism | Dementia | ☐ |
| ☐ | Rheumatoid Arthritis | Osteoporsis | ☐ |
| ☐ | High Cholesterol | Other | ☐ |

**If Other Please Specify** :

**Do You have any Allergies?** (e.g Antibiotics/Foods/Bee Stings/Latex)

YES ☐ NO ☐

**If YES Please Specify :**

**If you Have a Family History of any of the above Conditions Please State including which Relative:**

## Identifying Patients with Disabilities and other needs - Are you:

☐ registered blind partially sighted
☐ registered deaf registered deaf/blind
☐ on the learning disabilities register
☐ have a visual impairment
☐ have hearing difficulties
☐ or use a hearing aids

Do you have any information or communication needs when attending the surgery or receiving calls and letters from us?

Are you happy for these requirements to be shared with other healthcare professionals?

Yes ☐ No ☐

**Please answer the following questions by circling the most appropriate answer and add up your total score and place in the total score box.**

| Alcohol Screening Questions | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking | 1 or 2 | 3 or 4 | 5 or 6 | 7 or 8 | 10 or more |
| 3. How often during the last year have you found that you were not able to stop drinking once you have started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| No. of points scored (please add up your points) | | | | | |

TOTAL SCORE

☐

**If your total score is 5 or more please continue to complete alcohol screening audit on page 8. If your score is below 5 skip to page 9**

**Please answer the following questions by circling the most appropriate answer, place the score for that answer in the column (your score) at the end of each row. Then calculate the total score and put this answer in the box provided.**

| | **0** | **1** | **2** | **3** | **4** | Your score |
|---|---|---|---|---|---|---|
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times/m th | 2-3 times/w k | 4+ times/w k | |
| How many units of alcohol 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 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 | |
| How often in the last year have you needed an alcoholic drink the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 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 | |
| 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 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 | |

TOTAL SCORE

| |
|---|
| |

## Summary Care Record

The new NHS Summary Care Record was introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

**What is the NHS Summary Care Record?**
The Summary Care Record will contain basic information about any **allergies you may have, unexpected reactions to medications and any prescriptions you have recently received**. The intention is to help clinicians in Hospitals, Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.
Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary and this will not affect the standard of care you will receive.

**Children under the age of 16**
Patients under 16 years will not receive this letter, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.**

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you decide to proceed, but at any time in the future you, or a child you are responsible for, change your mind and choose not to have a Summary Care Record, all you need do is write to your Surgery informing them of your decision to "Opt-out". If you have already told your Surgery that you wish to "Opt-out" and you wish this to remain in place you need take no further action.

**Please Tick the Appropriate box and Sign and Date Below :**

| | |
|---|---|
| **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you. | ☐ |
| **Undecided -** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff within 12 weeks. If you do nothing, after this time, we will assume that you are happy with these changes and create a Summary Care Record for you. | ☐ |
| **No I do not want a Summary Care Record –** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff. | ☐ |

| **Signed;** | **Date:** |
|---|---|
| | |

***If you do not wish to Consent to Sharing your Summary Care Record please complete the opt out form on the following page...***

Your emergency care summary

CONFIDENTIAL

# OPT-OUT FORM

## Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

Title ............................................ Surname / Family name ..........................................................................

Forename(s) ..........................................................................................................................................

Address ..................................................................................................................................................

Postcode ................................ Phone No ................................ Date of birth ................................

NHS number (if known) ................................................................ Signature ................................

B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ................................................................................ Your signature................................

Relationship to patient ................................................................ Date ................................

**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 bad 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, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no Date ................................................

Ref: 4705

Opt_Out_V2.indd 1 30/06/2011 15:48

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# PATIENT CONSENT FORM

Consent for a carer, partner, family member or friend to be the patient's representative when dealing with prescriptions, blood tests results, medical treatment, or other aspects of their care. If you need consent for more than one individual you will need a further form please ask at reception.

## PATIENTS DETAILS

| Title | | Surname | |
|---|---|---|---|
| First Name | | Gender | |
| Date of Birth | | NHS No | |
| Address | | | |

## PATIENTS REPRESENTATIVE

This form authorises the surgery to allow the named representative to deal with aspects of your medical care. This will authorise the surgery to override the normal Caldicott Guardian Guidelines and Data Protection Laws on patient confidentiality and allow your representative to act on your behalf.

| Relationship to Patient | |
|---|---|
| Title | |
| First Name | |
| Date of Birth | |
| Surname | |
| Address | |
| Telephone Number | |
| Gender | |

- I confirm that I understand that by consenting to my representative dealing with my medical care on my behalf, they will know about my medical conditions.
- I also understand that The Bridge Surgery reserves the right to only deal directly with me,
  Where they feel it is appropriate to do so.
- I will inform The Bridge Surgery in writing if I wish to withdraw this consent.

| **Signature of Patient** | | **Date** |
|---|---|---|

| **FOR OFFICE USE ONLY:** | |
|---|---|
| **Signature of staff member** | |
| **Date** | |
| **Photo ID seen** | |
| **Name of staff member if they are personally vouching for patient** | |

| **Electronic Prescription Service:** The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, or want to put a nominated pharmacy in place going forward, please state the name and address of this pharmacy: | |
|---|---|

| **IMPORTANT INFORMATION:**<br>Your named GP will be allocated via your surname but you are able to book appointments with any of the GP's.<br>A – G will be Dr Caranci<br>H – M will be Dr Franklin<br>N – Z will be Dr Tayara | |
|---|---|
| Patient Signature: | |
| Date: | |
| Should you require any further information about the Practice please refer to the Practice Website: http://www.thebridgesurgery.co.uk or speak to Reception. | |
| If you required any further information about how we use your medical records and information on Practice Fair processing and Privacy Notice please refer to our website http://www.thebridgesurgery.co.uk or speak to Reception | |

**RECEPTION USE ONLY**

| Verification of Identity | |
|---|---|
| Verification of Address | |
| Height / Weight / BP Slip Attached | |
| Signed off by: (Name) | |
| Date: | |