Three Chequers Medical Practice

# Welcome to our Practice

Thank you for registering with us. Our aim is to provide services and facilities that will contribute towards a healthy future for you. As part of the registration process we ask you complete the enclosed pack – this will give us all of the information we need to ensure we have everything we need to provide you with the care you want and need.

Once you have completed all of the enclosed documents, please return this to the Practice along with two forms of identification (at least one of which must have a photo **and** current address – like a driving license – and the other must be either Photo ID or Address verification – a passport or recent utility bill).

Please complete all sections in **BLOCK CAPITALS**.

(Please be aware that this document is "double-sided")

| **1.** | **Personal Details** | | |
|---|---|---|---|
| First Name | | Sex | Male Female |
| Middle Name(s) | | Date of Birth | |
| Surname | | Place of Birth | |
| Address | | | Postcode |

| **Parental Responsibility** – please provide birth certificate or court order to confirm | | | |
|---|---|---|---|
| Mother's Full Name | | Father's Full Name | |
| Date of Birth | | Date of Birth | |
| Next of Kin? | ☐ | Next of Kin? | ☐ |
| Telephone Number | | Telephone Number | |

| **2.** | **Communication Preferences** | |
|---|---|---|
| ***Important Information*** Please read the Guidance Note "SMS / Email consent" (page 2) before completing the SMS / Email Consent. | | |
| *Only enter your contact information below (if you are entering the details of a carer or another individual then you must have their consent to do so).* | | |
| Communication Type | Telephone Number | Primary Contact (tick only one) |
| Mobile Telephone | | ☐ |
| Landline Telephone | | ☐ |
| Email Address | | |

| **3.** | **Background Information** |
|---|---|
| Previous GP Name | |
| Previous GP Address | |
| Country of Birth | |

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| Ethnic Origin | White (British) ☐ | Chinese ☐ | Pakistani ☐ | Prefer not to say ☐ |
|---|---|---|---|---|
| | White (Other) ☐ | Indian ☐ | Bangladeshi ☐ | Other (Specify) ☐ |
| | Black (African) ☐ | Black (Caribbean) ☐ | Arabic ☐ | |

| Religion | C of E ☐ | Buddhist ☐ | Sikh ☐ | Atheist ☐ |
|---|---|---|---|---|
| | Catholic ☐ | Muslim ☐ | Jewish ☐ | Other (Specify) ☐ |
| | Other Christian ☐ | Hindu ☐ | Jehovah's Witness ☐ | |

| Living Accommodation | House ☐ | Bungalow ☐ |
|---|---|---|
| | Mobile Home ☐ | Bedsit ☐ |
| | Lodging ☐ | Temporary ☐ |
| | Ground Floor Flat ☐ | Upper Floor Flat ☐ |
| | Warden attended accommodation ☐ | Residential Home ☐ |
| | Homeless ☐ | Nursing Home ☐ |

| Employment | Student ☐ | Other (please specify) ☐ |
|---|---|---|

| 4. | Language and Communication | | | | | |
|---|---|---|---|---|---|---|
| Language | First Language | | | | | |
| | Second Language(s) | | | | | |
| | Do you have any communication needs? | | | | Yes ☐ | No ☐ |
| | Hearing Loop | ☐ | Braille | ☐ | Translation services ☐ | |
| | Large Print | ☐ | British Sign Language | ☐ | From English – To (specify) | |
| | "Easy-Read" | ☐ | Makaton Sign Language | ☐ | | |

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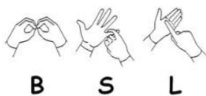
**Communicating with you**

We want to communicate with you effectively, regardless of any difficulties you have in understanding how our letters, leaflets and other material is provided.

When write to you or contact you, do you need us to communicate in a particular way? **Yes** ☐ **No** ☐

If your answer is "Yes", please tell us how using the boxes below. You may tick more than one box, but please make your preference clear.

| | | | |
|---|---|---|---|
| | By Telephone | I prefer to use the telephone and I use a Hearing Aid. ☐ | I prefer to use the telephone and I don't use a Hearing Aid. ☐ |
| | By Email | I do not use a Screen Reader ☐ | I use a Screen Reader ☐ |
| | By Test Message (SMS) | I use a Text-to-speak app ☐ | I do not use Text-to-speak app ☐ |
| | With Easy Read pictures and words | ☐ | |
| | By using **Large Type** | ☐ | |
|  | I need a British Sign Language Interpreter | ☐ | |

**If you need anything that is not on the list, please tell our receptionist when you come in and we will do our best to meet your needs.**

| **5.** | **Carers** | | | |
|---|---|---|---|---|
| Please read the guidance note "Carers" (page 5) before completing this section. | | | | |
| Are you a Carer? | | Yes ☐ | | No ☐ |
| Name of person for whom you care | | | | |
| Relationship to you | | Spouse ☐ | | Neighbour ☐ |
| | | Friend ☐ | | Other ☐ |
| What care do you provide for them? | | | | |
| Are they a registered patient of the Three Chequers Medical Practice? | | | Yes ☐ | No ☐ |

**Guidance Note – Carers**

A Carer is someone who provides day-to-day help for another who would not be able to manage without that help.

Is there someone who relies on you to be that person so much so that, if you went away for a day or two, they wouldn't cope? If so, then **you are a carer.**

At Three Chequers Medical Practice, we want to support carers in whatever way we can.

It could be a friend, neighbour or family member, but as a carer you play a vital role in, not only their life, but also the wider community and we want to know about the carers in our community so that we can keep you updated about all of the events, activities and support we can provide, or can support you to find.

Our practice lead coordinates all of our activities and events for carers and can give you advice or support depending on your situation. Contact the practice for more information.

| **6.** | **Medical History** | | | | |
|---|---|---|---|---|---|
| Have you ever suffered from any of the following conditions? | | | | | |
| Asthma | ☐ | Cancer (information below) | ☐ | COPD | ☐ |
| Depression | ☐ | Diabetes | ☐ | Epilepsy | ☐ |
| Heart Disease | ☐ | Heart Failure | ☐ | High-Blood Pressure | ☐ |
| Kidney Disease | ☐ | Stroke | ☐ | Underactive Thyroid | ☐ |
| **Any other condition, operations or hospital admissions or further information should be recorded below:** | | | | | |

| Family History – please record any significant family history of close relatives with medical problems and confirm which relative it refers to (brother, mother etc) | | | | | |
|---|---|---|---|---|---|
| Asthma | ☐ | Cancer (information below) | ☐ | COPD | ☐ |
| Depression | ☐ | Diabetes | ☐ | Epilepsy | ☐ |
| Heart Disease | ☐ | Heart Failure | ☐ | High-Blood Pressure | ☐ |
| Kidney Disease | ☐ | Stroke | ☐ | Underactive Thyroid | ☐ |
| **Use this space to record which relatives any medical problem relates to and to give further information** | | | | | |

| Allergies – please record known allergies or sensitivities below |
|---|
| |

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| Current Medication – please provide a list of medication in the space below. If possible, please also attach a list of your most recent repeat prescription |
|---|
| |

| If you suffer from a Long-term Medical Condition, then you will have to have an annual review of your Medical conditions to check that you are receiving the correct treatment.<br>Tick here to confirm that you understand this ☐ |
|---|

Immunisation History – please give details of immunisations that your child has been given.

| Age due | Immunisation | Comments | Batch # | Date given |
|---|---|---|---|---|
| 2 months | Diptheria / Tetanus / Whooping cough | | | |
| | HIB | | | |
| | Pneumococcal | | | |
| | Rotavirus | | | |
| 3 months | 2nd dose Diptheria / Tetanus / Whooping cough | | | |
| | HIB | | | |
| | Hep B | | | |
| | Rotavirus | | | |
| 4 months | 3rd dose Diptheria / Tetanus / Whooping cough | | | |
| | HIB | | | |
| | Hep B | | | |
| | Rotavirus | | | |
| 12-13 months | Measles, Mumps & Rubella (MMR) | | | |
| | PCV3 | | | |
| | HIB | | | |
| | Meningitis B | | | |
| 2 – 4 years | Flu Vaccine | | | |
| 3 – 5 years | Pre-school Booster Diptheria / Tetanus / Polio | | | |
| | MMR (2nd dose) | | | |
| 12 – 13 years (female only) | HPV (2 doses, 6 – 24 months apart) | | | |
| 14 years (School year 9) | Diptheria / Tetanus / Polio | | | |
| | Meningitis A, C, W & Y | | | |

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| Please give details of any other immunisations given (BCG etc) | | | |
|---|---|---|---|
| | | | |

| 7. | **Your Lifestyle** (continued) | | | | |
|---|---|---|---|---|---|
| Smoking – Delete as appropriate | | | | | |
| Do you smoke? | Never | | Ex-Smoker | | Yes |
| How many cigarettes do you / did you smoke a day? (delete as required) | 1 or less | 2 – 9 | 10 -19 | 20 - 39 | 40+ |
| Do you use an e-Cigarette or "Vape" | Never | | Ex-user | | Yes |
| Would you like help to quit smoking / "vaping" | Yes | | No | | For further information, please visit www.nhs.uk/smokefree |

| Height & Weight | |
|---|---|
| Height | Cm / Feet & Inches (delete as appropriate) |
| Weight | Stones & Pounds / KGs (delete as appropriate) |

| 8. | **Prescriptions** | | |
|---|---|---|---|
| Please read the guidance note "Dispensing Medicine" (following page) for more information. | | | |
| Dispensing | | | |
| Are you eligible to receive prescriptions dispensed by the Practice? | Yes ☐ | | No ☐ |
| Would you like to receive prescriptions dispensed by the Practice? | Yes ☐ | No ☐ | N / A ☐ |
| Electronic Prescribing | | | |
| Would you like the Practice to send your prescriptions electronically? If yes, please indicate which Pharmacy you would like us to use. | | | |
| Yes ☐ | No ☐ | | |
| Pharmacy name & location: | | | |

| I understand that I will have to undertake annual reviews of all Medicine I take | ☐ |
|---|---|

**Guidance Note – Dispensing Medicines**

We are a Dispensing Practice – this means we can dispense medication to some of our patients, depending on the reason or where they live.

Our main dispensary is in Porton, with a secondary dispensary located in Winterslow to serve the communities of these villages. We also have a small dispensary in our Endless Street branch for urgent prescription fulfilment.

Our dispensers receive excellent training and work exceptionally hard, ensuring that repeat-prescriptions and urgent prescriptions are dealt with in a timely manner.

If you normally pay for your prescriptions, you will still have to do so, prior to collecting your prescription. We take card and cash at all of our dispensaries.

As a general rule of thumb, if you live in one of the following villages, we are able to dispense medicine to you:

| | | |
|---|---|---|
| Pitton | Whaddon | Odstock |
| The Winterbournes | Alderbury | Nunton |
| Gomeldon | West Grimstead | Winterslow |
| Porton | East Grimstead | Coombe Bissett |

For patients living in these areas there are a few options on how you collect your medication; you can pop into your chosen Dispensary to collect your medicine; collect from one of our nominated "Collection Points" (Pitton Post Office / Alderbury Shop / Whaddon Post Office / Coombe Bissett Stores); or, if you're housebound, we can deliver the medicine to your door.

We aim to have all repeat prescriptions dispensed within **4 working days** of receipt during peak times.

Our Dispensary relies on the support of the village communities in order to survive, please use our service if you are eligible. Eligible prescriptions sent to a Pharmacy or online service threatens the long-term viability of our Dispensaries and your support is greatly appreciated.

If you are not eligible, or if you wish to, you can opt to have your prescriptions sent to another Pharmacy. Please give details of this in Section 9 of the Application Pack.

All patients of the Practice suffering from a Long-Term Medical Condition or receiving a repeat prescription must undertake an annual review of the Medical Condition(s) and medication with the Practice. This is to ensure that you are receiving the appropriate care.

| 9. | Further Details |
|---|---|
| Organ Donation Register | |
| From Spring 2020, Legislation is changing so that everyone in England is automatically registered as an Organ Donor.<br><br>If you would **not** like to be an Organ Donor, please tick here ☐ | |

| 10. | Sharing Consent |
|---|---|
| The Practice takes its responsibility under the Data Protection Act 2018 very seriously and wants you to make informed decisions about how your details are shared.<br>Please take a few moments to read the guidance "Sharing your Health Record" **before** continuing to provide consent.<br>After you have read the guidance note and understood the information, you will be asked to provide consent for sharing your information | |

| I have read and understood the Guidance entitled "Sharing your Health Record" (previous page) | ☐ |
|---|---|
| Do you consent to your GP Practice sharing your Health Record with other organisations who care for you? | |
| Yes (this is the recommended option) | ☐ |
| No, never (not recommended, please discuss this with a GP before deciding) | ☐ |
| Do you consent to your GP practice viewing your Health Record from other organisations that care for you? | |
| Yes (this is the recommended option) | ☐ |
| No (not recommended, please discuss this with a GP before deciding) | ☐ |
| Do you consent to having an Enhanced Summary Care Record with additional information? | |
| Yes (this is the recommended option) | ☐ |
| No (not recommended, please discuss this with a GP before deciding) | ☐ |

| Full Name | | | |
|---|---|---|---|
| Signature | | Date | |

## Guidance Note – Sharing your Health Record

The Three Chequers Medical Practice takes its responsibility under the Data Protection Act 2018 (incorporating GDPR) very seriously.
Please read this information very carefully to understand why, how and when the Practice might wish to share your information with selected other organisations and why we ask for your consent to other organisations sharing your health record with us.

**What is your health record?**
Your health record contains all of the information about the care you receive. When you need medical assistance, it is essential to that the Clinician(s) involved in your care can securely access your health record, in order to provide treatment that is tailored to you, based on your medical background. This may include your medical history, medication and allergies.

**Why is sharing important?**
By sharing your health record, you receive the best possible care and treatment – wherever and whenever you need it. Choosing not to share your health record could have implications on the quality of care and treatment you receive in the future.
Some examples of how you can benefit from the sharing of your record are:

- **Sharing your contact details** ensures you received medical appointments without delay
- **Sharing your medical history** ensures emergency services accurately assess you if needed
- **Sharing your medication** list will ensure that you receive the most appropriate medication
- **Sharing your allergies** prevents you from being given something to which you are allergic
- **Sharing your test results** will prevent you from having to repeat tests more than required

Furthermore, it is important that we can see information that other organisations have added to your health record to ensure that you are receiving the best treatment possible.

**Is my health record secure?**
Yes. There are numerous safeguards in place to make sure that only organisation authorised to view your record can do so. You can request information regarding who has accessed your information at any time.

**Can I decide who I share my health record with?**
Yes, we will always ask for consent to share your health record unless it is an emergency – if you are unconscious for example.

**Can I change my mind?**
Yes – at any time, just let us know.

**Can someone consent on my behalf?**
If you do not have capacity to consent, then a Lasting Power of Attorney (LPA) may be able to consent on your behalf. If you do not have an LPA, then a “best interest” decision can be made on your behalf by those caring for you.

**What about Parental Responsibility?**
If you have parental responsibility and your child is not able to make an informed decision, then you can make a decision about information sharing on behalf of your child. If your child is deemed “competent” (to make an informed decision) then the decision is theirs.

**What is a Summary Care Record?**
A Summary Care Record (SCR) contains basic information about you (contact details, NHS number, medications and allergies etc). GP Practices, Hospitals and emergency services can view this. If you do not want an SCR, then ask the Practice for an “opt-out” form. You can provide consent for an “enhanced” SCR which will include information such as care plans, which will help ensure that you receive the care you require in the future.

Further information can be found at www.nhs.uk/nhsengland/thenhs/records

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| 11. | Supplementary Information |
|---|---|
| | Please complete the following questionnaire. By providing this information, not only can we improve the care and service you receive from us, it can also improve the service you receive from other agencies including Hospitals and district nursing teams, should you need them. |

| **With whom do you live?** | | **Do you use a wheelchair?** | | | |
|---|---|---|---|---|---|
| I live with (please specify) | ☐ | Yes | ☐ | No | ☐ |
| | | If yes, what type of wheelchair do you use? | | | |
| I live alone (friends / family nearby) | ☐ | Self-propelled wheelchair | ☐ | Wheelchair pushed by another | ☐ |
| I live alone (no friends / family nearby) | ☐ | Motorised Wheelchair | | | ☐ |

| Relationship Information | | | |
|---|---|---|---|
| Immediate Family | Please list all living immediate family members (Spouse / cohabiting partner, children / dependants, parents etc)<br>**add extra sheets as required** | | |
| Full Name | Relationship | DOB | Patient of Practice? |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

| **Are you able to walk independently?** | | | |
|---|---|---|---|
| **Yes** (please specify below) | ☐ | **No** (please specify below) | ☐ |
| Walk without difficulty | ☐ | Walk independently with stick | ☐ |
| | | Walk with assistance from 1 person | ☐ |
| Walk independently with frame | ☐ | Walk with assistance from 2 or more people | ☐ |
| | | Unable to walk at all | ☐ |
| Walk independently with aids | ☐ | Confined to chair | ☐ |
| | | Bed-ridden | ☐ |

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| Mental Health - In the past 2 weeks, how often have you been bothered by any of the following problems (delete as appropriate) | | | | |
|---|---|---|---|---|
| Question | Not at all (1) | Several Occasions (2) | More than half of the time (3) | Nearly always (4) |
| Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed or hopeless | ☐ | ☐ | ☐ | ☐ |
| Trouble falling or staying asleep, or oversleeping | ☐ | ☐ | ☐ | ☐ |
| Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| Poor appetite or over-eating | ☐ | ☐ | ☐ | ☐ |
| Feeling bad about yourself – or that you are a failure and have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| Trouble concentrating on things, such as reading or watching the television | ☐ | ☐ | ☐ | ☐ |
| Moving or speaking so slowly that other people have noticed. Or being fidgety and restless a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| Thought about hurting yourself deliberately in any way | ☐ | ☐ | ☐ | ☐ |

| **12.** | **Parent / Guardian's declaration** – a person with Parental responsibility must complete this section. |
|---|---|
| I have completed this form to the best of my knowledge | ☐ |
| **First name** | |
| **Last name** | |
| **Signature** | |
| **Date** | |

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**Registration Checklist**

Please ensure you have completed and returned the following sections of the New Patient Registration Pack

| **Section Number & Title** | **Patient use** Tick to confirm completion | **Practice use** Tick to confirm receipt and preferences | |
|---|---|---|---|
| NHS Registration Form (GMS1) – ***without this we cannot register you*** | | | |
| 1. Personal Details | | | |
| 2. Communication Preferences | | | |
| 3. Background Information | | | |
| 4. Language and Communication | | | |
| 5. Carers | | Coded? | ☐ |
| 6. Medical History | | Medical information coded? | ☐ |
| 7. Your Lifestyle | | Smoker / Coded | ☐ |
| 8. Prescriptions | | Dispensing Patient? | ☐ |
| 9. Sharing Consent | | Enhanced SCR | ☐ |
| | | Consent to share (out) | ☐ |
| | | Consent for organisations to share with us (in) | ☐ |
| 10. Further Details | | Organ Donor - Opted out? | ☐ |
| 11. Supplementary Information | | | |
| 12. Parent / Guardian's declaration | | | |
| **2 forms of identification provided:** (documents of a person with Parental Responsibility are accepted) | | | |
| Passport | ☐ | ☐ | |
| Driving License (with current address) | ☐ | ☐ | |
| Utility Bill (with current address) | ☐ | ☐ | |
| Birth Certificate (or court order stating date of birth of child and parental responsibility) | ☐ | ☐ | |