|  |  |  |
| --- | --- | --- |
| Dr Venkata Suresh Babu Vitta -Partner  Dr Padma Babburi - Partner  Dr Sudha Sanathi – Associate  Dr Prem Lata Jairamani - Associate |  | **Selden Medical Centre**  6 Selden Road  Worthing  BN11 2LL  Tel: 01903 234962 |

**Registration Forms for Selden Medical Centre**

Before returning the forms to us, please check that **ALL** sections have been completed and are correct. We will not register you without all the required information. Evidence of residency is required for the owners/tenants of the property; this could be in the form of a utility bill, council tax bill or tenancy agreement dated within the **last 3 months**.

For anyone over the age of 16, we require a smoking status, alcohol consumption and height, weight and blood pressure. If you do not have the facility to find out this information at home, please contact the surgery and we will advise you when you can come into the surgery and use the equipment here. Please ensure you bring your registration form with you. Thank you.

…………………………………………………………………………………………………………………….

**Please keep this page for your information**

Surgery opening times

|  |  |
| --- | --- |
| Monday | 8:00am – 6:30pm |
| Tuesday | 8:00am – 6:30pm |
| Wednesday | 8:00am – 6:30pm |
| Thursday | 8:00am – 6:30pm |
| Friday | 8:00am – 6:30pm |
| Saturday | CLOSED |
| Sunday  Website:  www.seldenmedicalcentre.nhs.uk  Email address:  sxicb-wsx.smcinfo@nhs.net  Phone number:  (01903) 234962  Please note: prescription requests must be in writing; email or via the NHS app.  **We do not accept prescription requests over the phone.** | CLOSED |

Selden Medical Centre

New Patient Questionnaire

For reception - Type of ID:

Catchment postcode checked: Sign:

Please complete this form so we have some useful information about you before your old notes arrive and so that we can offer you services to help maintain your health.

Please show proof of name and address

**ABOUT YOU:**

Title…………Full Name………………………………Previous Name………………………………. Do you have a preferred Name?…………………………………………………………………….

Date of Birth: …....../…….. /.........

Gender: Male Female Other…………………………

**CONTACT INFORMATION**

Home telephone……………………………………………………….. Mobile telephone..…………………………………………………….. Work telephone………………………………………………………… Email Address…………………………………………………………..

Do you give permission for us to leave a message with someone (or on the answering machine) at the above contact points? Home: YES / NO - Work: YES / NO - Mobile: YES / NO

**Next of Kin**

Name……………………………………………………………………………

Telephone number………………………………….……………..................................... Relationship to you…………………………………………………………………………………

Do you give permission for your Next of Kin to discuss your clinical record on your behalf if needed?

YES / NO

**RESIDENCY**

Do you live in a residential/nursing home? YES/NO

Do you have a door access key code that you would like us to keep on record? ...............

**Are you a carer or do you help look after someone?** YES / NO

If you have a carer, please state their name / address / phone number:…………………….

………………………………………………………………………………………………………..

**ETHNICITY** :……………………………………

**Having information about patient’s ethnic groups is helpful to the NHS so that it can plan and provide culturally appropriate and better services to meet patient’s needs.**

**(This information is voluntary)**

Religious affiliation: …………………………………………………………… Nationality: ……………………………………………………………………… Main Spoken Language ……………………………………………………… Do you require the help of a Translator/Interpreter? YES / NO

**SERVICE FAMILIES AND MILITARY VETERANS**

I AM Military Veteran

I AM married/civil partnered to a Military Veteran I AM currently serving in the Reserve Forces

I AM married/civil partnered to a serving member of the Regular/Reserve Armed Forces I AM under 18 and my parent(s) are serving member(s) of the armed forces

I AM under 18 and my parent(s) are Veteran(s) of the armed forces

**ABOUT YOUR CURRENT HEALTH:**

Smoking status: Never Smoked

Ex-Smoker (Date Ceased: .........../……. / )

Current Smoker (How many per day… )

Smoker of e-cigarettes

What is your **height**? ……………………….. What is your **weight**? …………………………

What is your **blood pressure**? ……………………..

**REACTIONS TO DRUGS AND ALLERGIES**

Have you had a reaction to any medication, or do you suffer from any allergies?

**If so please give details**

....................................................................................................................................................

…………………………………………………………………………………………………………….

**FOR WOMEN ONLY**

**About cervical smears:**

Have you had a smear in the last 3-5 years?

Yes

No

**About contraception:**

What form are you using? ……………………………………………………………

If you have a coil, when was it fitted? ………………..What type is it? …………..……………

**Have you had a hysterectomy?**

Yes

No

If yes, when? ………………………..What was the reason? …………………………………

**HEALTH CONDITIONS**

Have you ever been **diagnosed** with any of the following conditions? (Please tick)

 Diabetes  Thyroid disease  Stroke or transient ischaemic attack

Cancer (please specify) …………………..

 High blood pressure

 Heart disease

 Learning disability

Are you **taking medication** for any of the following?

 Asthma

 Mental illness  Epilepsy  Other long term chest problem

Are you taking any **other prescribed medication**?  Yes No

If you have any other **health conditions** please give details:

**FAMILY HEALTH CONDITIONS**

Any other **health conditions** please give details:

Have any of your immediate family been diagnosed with any of the following conditions? (Immediate family is parents, siblings, grandparents or aunts/uncles)

 Diabetes  Thyroid disease  Stroke or transient ischaemic attack  Cancer

 High blood pressure

 Heart disease

 Learning disability

 Asthma

 Mental illness  Epilepsy  Other long term chest problem

****

**CURRENT MEDICATIONS**

Are you taking any repeat prescribed medication? Please give details:

****

**NHS ELECTRONIC PRESCRIPTION SERVICE**

The electronic prescription service (EPS) is a free NHS service which allows GP surgeries to send your prescriptions to your chosen pharmacy via a secure, electronic connection. Please tick if you consent to have your prescriptions sent to your nominated pharmacy.

 Yes I consent

No I don’t consent

**YOUR CHOSEN PHARMACY**

Please indicate the pharmacy for your prescriptions to be sent to (this can be any pharmacy, no matter how far away they are from the practice as long as the name and postcode are stated).

Worthing Pharmacy

East Worthing Pharmacy

Boots Montague Street

 Boots Lyons Farm

Other (please state name and postcode) ……………………………………………………………………………………………………………

If you are unsure which pharmacy you would like to use, please visit

**www.nhs.uk/service-search/pharmacy/find-a-pharmacy**

****

**ALCOHOL SCREENING TOOL**



**1 unit is typically:**

**UNIT GUIDE**

Half-pint of regular beer, lager or cider; 1 small glass of

low ABV wine (9%); 1 single measure of spirits (25ml)

**The following drinks have more than one unit:**

A pint of regular beer, lager or cider, a pint of strong

/premium beer, lager or cider, 440ml regular can cider/lager, 440ml “super” lager, 175ml glass of wine (12%)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4  times  per month | 2 - 3  times  per week | 4+  times  per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost  daily |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost  daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy  drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost  daily |  |
| How often during the last year have you been unable to remember what  happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

/40

**TOTAL SCORE**

16 – 19 Higher risk, 20+ Possible dependence

**SCORE**

**SPECIFIC NEEDS:**

Do you have any sensory needs (i.e Speech / Sight / Hearing) Are you an ‘Assistance Dog’ user? YES / NO

Please state any physical disabilities you have:…………………………………………………….. Please state any mental disabilities you have:………………………………………………………. Please state any requirements you have to be able to access our practice premises: …………

…………………………………………………………………………………………………………….. Please state any phobias you have:…………………………………………………………………...

Do you have any religious or cultural needs? …………………………………………………….....

Are you housebound? YES/NO

Are you a wheelchair user? YES/NO

Do you have a Lasting Power of Attorney? YES/NO

Please specify which kind of LPA: Health & Welfare/Property & Finance/Both

**PATIENT PARTICIPATION GROUP (PPG)**

Using surveys, the Patient Participation Group helps the practice decide and prioritise changes and improvements in the services we offer. Most of the communication will be via email, but will also be available on the practice website and in the surgery itself. If you would like to participate, please ensure we have your email address and tick the box. If you change your mind and want to withdraw consent at a later date, please contact the practice and speak to the practice manager.

I would like to be involved in the Patient Participation Group

**THANK YOU – NOW CAN WE HELP YOU?**

.

* If you would like help to give up **smoking** please make an appointment for our smoking cessation clinic.
* If you are **over 45,** or have a **family history** of high blood pressure or heart disease and have **not had your blood pressure recorded in the last 5 years,** or would like a health check, please make an appointment with a **Health Care Assistant**.
* If you are **house bound** and would like a health check please contact reception

**Please note that by signing this form you are agreeing that all of the information which you have provided is correct to your knowledge.**

**Signature : ……………………………………………………Date: ....../……. /……….**

**You can choose how your confidential patient information is used**

# SUMMARY CARE RECORD (SCR)

Your Summary Care Record (SCR) is a short summary of your GP medical records. It tells other healthcare staff about allergies and the medicines you take. This means they can give you better care when you are away from home, in an emergency, when your surgery is closed, at outpatient clinics or at the pharmacy. If you do not have an SCR, NHS healthcare staff caring for you may not be aware of your current medications, allergies and any bad reactions to medicines you have had, in order to treat you safely in an emergency. SCRs improve your care, but if you do not want one, tell your GP or complete the form below and return it to Reception. For more information on (a) having an SCR with core information only or (b) what will happen if you opt out completely, go to *https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information- for-patients*

# YOUR DATA MATTERS TO THE NHS

You can choose whether your confidential patient information is used for research and planning. Health and care information is used to improve your individual care. It is also used to help research new treatments, decide where to put GP clinics and plan for the numbers of doctors and nurses in your local hospital. Wherever possible, we try to use data that does not identify you, but sometimes it is necessary to use your confidential patient information. It is used by the NHS, local authorities, university and hospital researches, medical colleges and pharmaceutical companies researching new treatments. If you are happy about how your confidential information is used, you do not need to do anything. **You can choose not to share your data either online at** [***www.nhs.uk/your-nhs-data-matters***](http://www.nhs.uk/your-nhs-data-matters)**or through a telephone service (0300 303 5678)**. If you opt out of this, you will still be invited for screening services eg bowel cancer.

**I want to choose how my confidential information is used**

Name: ………………………………………………………….………… Date of birth: ………………………………….….. Address: ………………………………………………………………………………………………………………………………… Signature: ……………………………………………………..……….. Today’s date: …………………………………..…… If completing for another person, your name/signature and relationship to that person:

…………………………………….…………………………………………………………………………………………………………

* I do not wish to have my clinical information in the **Summary Care Record**
* Text messages – I do not wish to receive **text messages**
* Emails – I do not wish to receive **emails** (Note: this will prevent you using Online Service

|  |  |
| --- | --- |
|  | PRACTICE |

**SELDEN MEDICAL CENTRE**

**Patient access to records; Online GP electronic health record viewing system consent form**

|  |
| --- |
| **Name of Patient: Date of birth:** |
| **Address:** |
| **Telephone Number(s) Home: Mobile:** |
| **Email of Patient:** |

# Terms and conditions

# I have read, understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice (see attached) | **🞏** |
| 1. I will be responsible for the security of the information that I see or download | **🞏** |
| 1. If I choose to share my information with anyone else, this is at my own risk | **🞏** |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | **🞏** |
| 1. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice. | **🞏** |

**I would like to have access to the following services (please tick to select)**

|  |  |
| --- | --- |
| Booking Appointments and requesting repeat medication\* | 🞏 |
| Access to medications and allergies \*\* | 🞏 |
| Access to test results and immunisation history \*\* | 🞏 |
| Access to consultations and documentation \*\* | 🞏 |

\*immediate access will be granted upon receipt of this form and photographic ID

\*\* if you have ticked these options then this will need to be approved by a doctor – this can take around 30 days

Please note: by having access to your medical records on-line you may have access to test results and investigations before the GP has viewed and commented on them. Should you be concerned about any entry on your GP record, please contact the practice.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of patient  (please sign at the surgery) |  | Date |  |

### For practice use only

|  |  |
| --- | --- |
| Identity verified through  (tick all that apply) | Photo ID – Passport or Photo Driving Licence 🞏  Proof of residence 🞏  Other 🞏 |
| Staff Member full name:  ……………………………………………………… | 🞏 tick to confirm that you have verified the patients email address and contact number? (amend EMIS if required)  🞏 tick to confirm that you have issued initial email which gives patient password and details of how to register |



**Patient Online: Records Access**

**Patient information leaflet ‘It’s your choice’**

|  |  |
| --- | --- |
| 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. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.  Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. In general this decision will not affect the quality of your care.  You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.  **The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.** | **Repeat prescriptions online**  **GP appointments** **online**  **View your GP records**  **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**  **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**  **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.** |

|  |
| --- |
| 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. |

|  |  |
| --- | --- |
| *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. |

|  |
| --- |
| More information For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:  [‘Keeping your online health and social care records safe and secure’.](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf) |