New Patient Questionnaire

Ashfield Medical Centre

For all patients registering with this surgery

Welcome

Thank you for your interest in registering with Ashfield Medical Centre. In order to register, please complete the attached forms, and make an appointment with the registration clerks at the surgery.

1. Please fill out ALL paperwork
2. Sign the GMS1 Family Doctor Services Registration
3. Sign Agreed Principles form (Patient and Doctor agreement)

Post back/hand deliver/email with a copy of ID and proof of address (accepted proof listed below). Email address: registrations.ashfieldmc@nhs.net

Any queries, please contact 01908 679111 option 5 - registrations

Suitable forms of ID

Please provide two forms of ID, one of which should be photographic, and the other which should confirm your address (and be dated within the last 3 months). Please see below for examples of suitable ID. **We do not accept bank statements as proof of address.**

Photo ID	Proof of Address
• Passport	• Utility Bill
• Driving Licence	• Council Tax Bill
• Visa/Leave to Remain Card	• Tenancy Agreement
• Other photographic evidence	• Insurance Documents
	• Payslip

If you are not a British Citizen you will need to provide your Passport or European Citizen card as photographic ID

A new born baby will require the original copy of baby's birth certificate. Exclusions of proof of address apply for babies/children/residents of care home) but please bring along the 'Red Book' for children

Car Park

There is car parking both at the front & back of the building. There are limited disabled spaces within the front car-park **for blue badge holders only**.

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If you need any support completing these forms please ask our reception teams who will be happy to help you. Please ensure you complete the Purple GMS (General Medical services) form clearly at the front of this leaflet.
You can obtain your NHS number from your previous GP surgery.
We do understand that not all questions on our registration forms are applicable to all patients. However it is important we use the registration process to capture as much information as possible. This is to ensure that we are offering you the best standard of care and can signpost patients who may need extra support at the point of registration. Please complete the registration forms to the best of your knowledge with as much information as possible.

PATIENT NAME	**DOB**

We recommend that patients provide identification when registering at the practice. If you're unable to provide identification we can still register you. However you won't be able to access our online services without proof of identification.

We do recommend patients sign up for online services.

Have you been registered with our GP Practice before? Yes ☐ No ☐

If you have previously been de-registered under our zero-tolerance scheme you must not register with our practice, without first writing to the Practice Manager with your request. If the practice declines your request to register they will inform you in writing of the decision. The practice has a right to remove your registration at their discretion at any time if you have previously been removed from our list for abusive behavior and not informed them at the point of re-registering.

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments ☐
2. Requesting repeat prescriptions ☐
3. Accessing my medical record ☐

Please provide photographic identification and proof of address to register with our online services.

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TEL No (home):	TEL No (work):
TEL No (mobile)	EMAIL ADDRESS
Consent for SMS messages Do you consent to us contacting you by SMS messages Yes ☐ No ☐	Consent for email correspondence Do you consent to us contacting you by email Yes ☐ No ☐

NEXT OF KIN:
Name
Address (including postcode)
Contact number
Your relationship

Would you like to be provided with an ACP booklet (Advanced Care Planning) Yes ☐ No ☐

Advance care planning is a process that enables individuals to make plans about their future health care.

Name & address of Nominated Pharmacy for prescriptions	

SUMMARY CARE RECORD

Your records will automatically be coded for an Enhanced Summary Care Record.
If you do not want a summary care record, please ask at reception for an OPT out form and tick here ☐

Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. It means they can give you better care if you need health care away from your usual doctor's surgery: for example, in an emergency, when you're on holiday, when your surgery is closed, at out-patient clinics or when you visit a pharmacy.

THIRD PARTY ACCESS

In the Practice we aim to provide you with the highest quality of healthcare. To do this we must keep records about you, your health and the care we have provided or plan to provide to you. Everyone working for the NHS has a legal duty to keep information about you confidential.
If you would like a family member or carer to have access to your medical records on your behalf. We need to keep their contact details on your records.
The person you nominate must be happy to have their details recorded in your medical records. If you wish to nominate someone for this reason please provide us with their details and sign below that you consent to this

Name of nominated individual ………………………………………….

Your signature …………………………………….. date ………………………

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First Spoken Language:	English	Other (Please state) Do you require an interpreter?	Asian or British Asian	Black or British Black ☐	Other

Sub-group:	British	Irish	Other White	Mixed	Indian	Pakistani
	Bangladeshi	Other Asian	Caribbean	African	Other Black	Chinese

LIFESTYLE

Blood pressure reading (please use pod in reception if available)	

HEIGHT:		WEIGHT:		
DO YOU SMOKE? NEVER / EX-SMOKER / YES*			HOW MANY PER DAY?	
Do any of the following apply	Pipe	Roll ups	Vaping	Cannabis

Would you like help to stop smoking	Yes	Not at this time

PERSONAL MEDICAL HISTORY
(please tick any that are relevant and write the date of diagnosis where possible)

ANGINA	ARTHIRITIS	ASTHMA
CANCER	DIABETES	EPILEPSY
HIGH BLOOD PRESSURE	LEARNING DISABILITIES	OSTEOPOROSIS
MENTAL HEALTH SUPPORT	SKIN DISEASE	THYROID DISEASE
COPD	OTHER -	
Please list medicines taken for the conditions above		

FAMILY HISTORY

HEART PROBLEMS (i.e. ANGINA/HEART ATTACK)	YES / NO	RELATIONSHIP / AGE:
STROKE (CVA)	YES / NO	RELATIONSHIP / AGE:
CANCER	YES / NO	RELATIONSHIP / AGE:
DIABETES	YES / NO	RELATIONSHIP / AGE:
ASTHMA	YES / NO	RELATIONSHIP / AGE:

MEDICATION

Medication: If you are taking regular medication from your previous GP you will need to book an appointment before our G.P's can issue this, please allow yourself plenty of time so you do not run out of medication and bring along any previous prescription requests / medication with you to appointment. Please note we do not accept prescription requests over the phone unless you are housebound and prescriptions take 48-72 hours to be processed.
LIST ANY OVER THE COUNTER MEDICATION USED REGULARLY
PLEASE ADVISE OF ANY KNOWN ALLERGIES

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New Patient Health Check

Would you like to be booked an appointment for a new patient health check with our HCA (Healthcare Assistant)? You can choose at the appointment to have a quick and simple test for HIV if you wish to do so. As part of your registration process please advise us if you would like to opt out of this

I would like to be booked an appointment for a new patient health which will include the option of a HIV test	Yes ☐ No ☐

VETERANS

ARE YOU OR HAVE YOU SERVED IN THE ARMED FORCES? What is your service number …………………………………..	Yes	No

CARERS

ARE YOU A CARER FOR SOMEONE ELSE?	Yes	No

IS THERE SOMEONE YOU RELY ON FOR YOUR CARE? (please circle)	family	friend	Paid carer	Social care support

WOULD YOU LIKE TO BE REFERRED TO CARERS MK	Yes	No

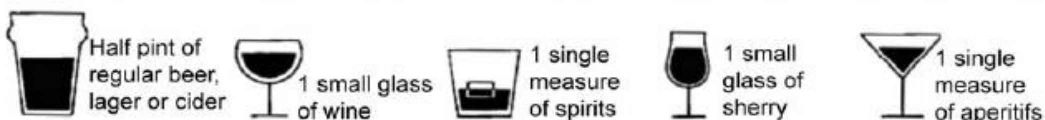
WOMEN ONLY

I HAVE HAD A HYSTERECTOMY AND THEREFORE DO NOT REQUIRE A SMEAR TEST	(Please √)

DO YOU DRINK ALCOHOL – Please complete below by circling your answers

FAST	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Weekly (3) or Daily (4). Stop here if the answer is Never (0), Less than monthly (1) or Monthly (2).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

This is one unit of alcohol…



…and each of these is more than one unit

COMMUNICATION

We want to make sure you can read and understand the information we send you. If you find it hard to read letters or if you need someone to support you at appointments, please let us know in the answers given below.

Patients with hearing impairment

Do you lip-read or use a hearing aid or other communication tool?	YES	NO
IF SO, WHICH?		

Do you need a British Sign Language interpreter or advocate with longer appointment times?	YES	NO
IF YES, WHICH?		

Patients with visual impairment

Do you need information in another format? For example, large print or easy to read?	YES	NO
IF YES, WHICH?		

All patients

How would you prefer us to communicate with you? (PLEASE CIRCLE)	LETTER	EMAIL	TEXT	OTHER
IF OTHER, PLEASE STATE WHAT?				

Is there any other communication support we should provide for you?	YES	NO
IF YES, PLEASE STATE WHAT?		

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Consent

I consent to the practice contacting me by text message and/or email message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text and/or email are an additional service and that these may not take place on all/or on any occasion and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text and/or email message facility at any time.

Text messages are generated using a secure facility however I understand that they are sent over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be indentified.

I agree to advise the practice if my email address changes and also if my mobile telephone number changes or if this is no longer in my possession.

The practice does not share mobile phone contact details or email addresses with any external non-NHS organisation.

Your medical records may be used for financial or clinical audit, post payment verification checks, medical research or education purposes.

Signature	Date

I confirm that the information given above is accurate to the best of my knowledge and that I live within the practice boundary catchment area as detailed in this pack and I confirm that I have read and understood the **Contract of care** provided in this pack

Signature	Date

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Do you live in a care home ?	Yes	No

Alternatively if you are homeless or at risk of homelessness please complete the information below. The reason we ask for this information is so that we can send a referral to the local homelessness team

Are you homeless Do you give your consent for a referral to MK homelessness team			Yes Yes	No NO
Are you threatened homelessness			Yes	No
What date do you expect to become homeless				
National insurance number				
Current living situation	You	Couple	Family with dependents	Family with no dependents

Owner	Private rented	Council tenant	Housing Association tenant	Living with parents
Staying with friends	Sleeping rough	Hostel	Night shelter	other

Please be aware once the referral has been sent, the practice will be unable to provide you with further information regarding the referral .The homelessness team will contact you directly.

You can only register at our practice if you live within the catchment area for our practice. Please only submit your registration if you live within the areas below – IF you have completed this form and do not live in our boundary area you can take this form to any surgery in Milton Keynes close to your home address

Practice Boundary area

Ashland	Beanhill	Browns Wood	Campbell Park
Central MK	Coffee Hall	Eaglestone	Fishermead
Granby Court	Leadenhall	Kents Hill	Kents Hill Park
Middleton	MK Village	Monkston	Monkston Park
Netherfield	Old Farm Park	Oldbrook	Peartree Bridge
Simpson	Springfield	Tinkers Bridge	Walnut Tree
Walton	Walton Park	Wavendon Gate	Woolstone
Woughton		Woughton On The Green	

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Contract of Care

The GPs, Nurses, Practitioners and Staff aim to provide the highest possible care to our patients. The aim of this Contract of Care is to ensure that you understand the practice policies, why such policies are in place and then follow them. We particularly recommend that you read closely the details relating to our Appointment, Repeat Prescribing and Behaviour expectations.

Your responsibilities:	Practice responsibilities:
Comply with recommended treatment	Offer access to quality medical services
Participate in appropriate screening and prevention programmes	Provide you with an appointment with a GP or appropriate healthcare professional or signpost you to a suitable alternative service in line with our appointments procedure
Commit to a healthy lifestyle with support from the Practice if required.	Enable you to relevant appointments with the right clinician the first time
Treat clinicians and staff with dignity and respect at all times.	Treat you with dignity and respect at all times.
Be aware of our practice booking system and use this appropriately and book with the appropriate clinician	Ensure all patients have access to a patient information leaflet which includes information of how to book an appointment

Information about all the services we provide are detailed on our website If you do not have access to the internet please ask at reception for a practice leaflet . Before deciding that you wish to join the Practice we ask that you review this information in order to decide whether you can follow the policies presented by the Practice in line with the General Medical Services GP contract.

AGREED PRINCIPLES BETWEEN DOCTOR AND PATIENT

The Patient and Doctor agree that:-

1. Appointments are made for one person at a time. Please do not bring anyone else to see the doctor unless they have their own appointment.
2. Should you present with multiple problems your doctor may ask you to make another appointment to discuss them.
3. Patients arriving more than 10 minutes late for their appointment may be asked to re-arrange it.
4. If you no longer need a previously booked appointment, please try and cancel at least 24 hours before the due date.
5. Patients who do not attend two or more appointments with a doctor or nurse without prior cancellation may be removed from our practice list.
6. Patients who make inappropriate use of any service, in particular emergency services when the surgery is closed, may be removed from the practice list.
7. The practice aims to treat all our patients with respect and dignity. We expect the same courtesy to be extended to all our staff.
8. The Practice operates a zero tolerance policy in respect of verbal and physical abuse towards staff. Any incident will result in the patient being removed from our practice list.
9. Any complaints or suggestions should be addressed to Mrs Di Robertson, Practice Manager.
10. Please sign and date this agreement and return at the time of registration.

Patient’s Signature: ………………………………… Date: ……………………………………