Harley Street Medical Centre

New Patient Questionnaire

Additional Contact Information

Name:…………………………….   D.O.B:………………..

Mobile Number:…………………......

Home Telephone Number:……….……..

Consent for Text Messages:

☐ Yes ☐ No

Consent for Emails:

☐ Yes ☐ No

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 and telephone no.
……………………………………………………………………………………

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

Asian or Asian British: Any other Asian background ☐

Asian or Asian British: Bangladeshi: ☐

Asian or Asian British: Chinese ☐

Asian or Asian British: Indian ☐

Asian or Asian British: Pakistani ☐

Black or African or Caribbean or black british: African ☐

Black or African or Caribbean or black british: Caribbean ☐

Black or African or Caribbean or black british: other black, african or Caribbean background ☐

Mixed multiple ethnic groups: any other mixed or multiple ethnic background ☐

Mixed multiple ethnic groups: White or Asian ☐

Mixed multiple ethnic groups:White and black African ☐

Mixed multiple ethnic groups:White and black Caribbean ☐

Other ethnic group: any other ethnic group ☐

Other ethnic group: Arab ☐

White: any other white background ☐

White: English or Welsh or Scottish or Northern Irish or British ☐

White: Irish ☐

Next of Kin: …………………………..

Contact details for Next of kin:……………………………………………………

Additional Information
Height: Weight:

Exercise: Allergies:

As a practice we offer new patient appointments, would you like to book one: Yes/No
Are you taking any regular medication? Please list;(use additional sheet if required)

Would you like to use the electronic prescription service? If so please nominate a pharmacy:……………………………………………………………………………………
…………………………………………………………………………………….......

Have you ever served in the British Armed Forces? Yes ☐ No ☐

Smoking status - Over 16 yrs

Current Smoker ☐ → Number per day …………..

Current Non-Smoker ☐ → Date/Year Stopped Smoking ……………

Never Smoked Tobacco ☐

Do you require smoking cessation advice Yes ☐ No ☐

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 ☐

Main Language: ……………………………………………….

Deafness – require a sign language translator ☐

Disability – require a carer ☐

Female Patients only

In order that we can arrange the correct follow-up, please let us know if you are using either of the following contraceptive devices:-

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

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

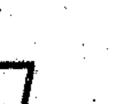
AUDIT

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains 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 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 failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in 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

UNITS

2



9

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.

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.**

Information for our patients.

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

Summary Care Record

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.

This means they can give you better care if you need health care away from your usual doctor's surgery:

- in an emergency
- when you're on holiday
- when your surgery is closed
- at out-patient clinics
- when you visit a pharmacy

☐ **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.

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

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

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	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation

FOR PRACTICE USE ONLY

	Checked By (Initials)
Registration Form completed and signed	
Ethnicity completed	
Alcohol Screening Questions completed	
Smoking Status completed	
SCR option selected (Opt-Out Form completed if dissent given)	
ID Verified and photocopied	
New Patient Screening appt made	
Given Named GP letter	
Check if requesting online access and if so sign to say you have seen ID	

Accessible Information Needs Questionnaire

At Harley Street Surgery we want to make sure that we give you information in a way that is clear to you, and to have on record any communication needs you might have.

The NHS Accessible Information Standard aims to ensure those patients and their carers who have a disability, impairment or sensory loss can receive access and understand information, and that they receive professional communication support if they need it.

This questionnaire has been designed to give you the opportunity to inform us if you have any difficultly in reading or understanding the information that we send you and record your preferred way of communicating with the surgery and its staff.

	Your details	Please fill in the boxes below
	Your full name	
	Your date of birth	

	Today's date	

	Question	**Please tick**	
1.	Do you have any communication or information needs which are related to a disability, impairment, sensory loss or learning disability?	Yes	
		No	
2.	When we write to you or contact you, do you need us to communicate in a particular way?	Yes	
		No	

If your answer is **NO** to questions one and two above, **please sign and date** the form and return to the reception staff. If you have answered **YES** , please complete the rest of this form overleaf.

	Question	**Answer**
3.	What disability, impairment, sensory loss do you have that affects your communication or information needs?	

Please choose your preferred method for us to contact you with information, such as a letter to invite you in for a flu vaccination:

	Method or Format	**Please tick or provide details**
TXT	**Text** (please confirm the number)	

	Method or Format	Please tick or provide details ✔
Results	**Large print**	
	Easy read document	
	Other (please tell us what this is)	

		Question	Please tick ✔	
4.		When you come into surgery for an appointment do you need a British Sign Language interpreter?	Yes	
			No	
5.	Share?	Can we share this information with other health and social care providers (for example if you needed to attend an outpatient clinic at hospital)?	Yes	
			No	

Thank you for completing this form, please return it to the reception. We will update your patient records so that every time you book an appointment or we need to contact you we will do so using your preferred method.

You can find more information about the NHS Accessible Information Standard on NHS England's website https://www.england.nhs.uk/ourwork/patients/accessibleinfo/

or on the surgery's website: www.harleystreetmedicalpractice.org.uk

Please return this completed form to reception.