MEDICAL PARTNERSHIP
OUR STRENGTH IS IN OUR CARE

Incorporating; Lintonville Medical Group, Wellway Medical Group, Brockwell Medical Group

New Patient Questionnaire (Adult)

When you register with us as a new patient, it would be helpful if you could provide evidence of your identification. This will help us to ensure we have the correct details, and can speed up the process of receiving your medical records from your previous surgery.

You can use any of the following documents:

- Passport
- Paid utility bill
- Payslip / P45 (if it shows address)
- Bank / building society cards / statements
- Driving licence
- Local authority rent card
- Papers from home office of UK Borders Agency
- Letter from the Benefits Agency / benefit book / signing on card

Please make an appointment with the Nurse for a New Patient Medical within one month of joining the practice.

New Patient Questionnaire (Adult)

For Office Use Only
ID seen? YES / NO
Patient informed of registered GP? YES / NO
Name of Registered GP: ____________________

Welcome to Lintonville Medical Group. Please complete this questionnaire as fully as possible. It gives us essential information about your health whilst we are awaiting your medical records.

Date: …………………………………..
Surname: ……………………………………………………………
Forename: ……………………………………………………………
Name known as: ……………………………………………………………
Date of birth: ……………………………………………………………
Marital status: Single / Married / Separated / Divorced / Widowed
Other (please state) ………………………………..
Address: ……………………………………………………………
……………………………………………………………
……………………………………………………………
Postcode: ……………………………………………………………
Home telephone number: …………………………………………………… ☐
Work telephone number: …………………………………………………… ☐
Mobile telephone number: …………………………………………………… ☐
(Please tick prefered contact number)
Email address: ……………………………………………………

Nominated pharmacy for collecting electronic prescriptions:	

If born outside of the UK, please states the date you first entered the UK?: ……………

Have you ever served in the armed forces? YES / NO
If yes, are you happy for this to be coded on your medical records? YES / NO

Next of Kin

Should we need to contact you urgently, or in the event of an emergency, we would be grateful if you could provide us with the following details:

Next of Kin: Mr / Mrs / Ms / Other (please state) …………………………

Name: ……………………………………………………..
Relationship: ……………………………………………………..
Address: ……………………………………………………..
……………………………………………………..
Postcode: ……………………………………………………..
Telephone number (s): Home: ……………………………………..
Mobile:……………………………………….

Non-prescribed Medication

Are you currently taking any medication which is NOT on prescription, e.g. that you buy from a chemist like Aspirin? YES / NO

If yes, please list below:

……………………………………………………………………………………………

……………………………………………………………………………………………

Important information about repeat medication.

If you are taking regular prescribed medication, you must provide us with a copy of your latest repeat medication list from your previous GP Surgery. This can be a recent prescription or a medication print-out from your previous GP. It is your responsibility to provide us with precise details of your regular medication as this will allow us to safely update your new patient medication records accordingly.

Have you attached / enclosed a printed copy of your repeat medication? YES / NO

Please note: If repeat medication information is not provided along with your new patient application this will delay your first request for medication.

Ethnicity – What is your ethnic origin? (please tick one box)

White British □
Other white ethnic group □
Black African □
Black British □
Black Caribbean / West Indies / Guyana □
Indian □
Pakistani □
Other Asian ethnic group □
Other ethnic group (please Specify)

Main spoken language: ………………………………………………………..
Do you need an interpreter: YES / NO

Smoking

I am a smoker □
(I smoke …..…. per day)
I am an ex-smoker □
(Date stopped …………..)
I have never smoked □

Allergies

Are you allergic to anything (including medicines)? YES / NO

If yes, what are they:

…………………………………………….............

……………………………………………………

……………………………………………………

Carer details

If over 18 years, do you have a carer? YES / NO

If yes, please state your carers name and relationship:
……………………………………………………………………………………………………

Are you a carer (eg. Look after someone with physical / mental health problems)?
YES / NO

If yes, please state the name and relationship of the person you care for:
……………………………………………………………………………………………………

Do you have any problems with your hearing or speech, which would prevent you from having a telephone consultation with the doctor? YES / NO

If yes, please state problem:
………………………………………………………………………………………………
………………………………………………………………………………………………

Do you have any problems with reading or writing? YES / NO

If yes, please state problem:
………………………………………………………………………………………………
………………………………………………………………………………………………

Alcohol – Please circle the answer which best applies to you. If you score 3 or more, this might indicate hazardous or harmful drinking and we suggest filling in the more detailed AUDIT alcohol questionnaire below.

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men) / 6 (woman) or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
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	
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	
Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total Score	

Guide to units:				
	A pint of regular beer / lager / cider	2 units	175ml glass of wine	2 units
	Single measure of spirit	1 unit	Bottle of wine	9 units
	Bottle of alcopop, or can of lager	1.5 units		

Alcohol Users Disorders Identification Test (AUDIT) – only to be filled in by people scoring 3 or more on the alcohol survey above.

Please circle the answer which best applies to you.

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 time per week	4+ times per week	
How many standard alcoholic drinks 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 of 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 of 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 of 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 of 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 of 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 of 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	

Scoring:

0 – 7 = sensible drinking
8 – 15 = hazardous drinking
16 – 19 = harmful drinking
20+ = possible dependence

If you score 8 or more, we would advise you to discuss the matter at your new patient check or make a separate appointment with a doctor or nurse.

Patient Consent

This form will be scanned into your electronic patient record. This information will be used to help the practice provide you with complete and appropriate medical care.

If you leave the practice, this information will be transferred with your medical record to the new practice.

Please sign below to give your consent. If you do not sign to consent, a member of the practice will contact you to discuss your options.

Signature of Patient: …...……………………………….

Print: …...……………………………….

Date: …...……………………………….

The practice uses SMS messaging to send patient appointment reminders and other appropriate clinical information.
If you have provided us with a mobile number and agree to the practice sending you this information via SMS please sign below.

Signature of Patient: …...……………………………….

Print: …...……………………………….

Date: …...……………………………….

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Patient Access – Patient Guidelines

Patient Access gives you online access to Patient Services via a secure website. Currently the services include:

Booking telephone appointments
Ordering repeat prescriptions
Medical record viewer (summary of your care record).

To register for this service, you must sign an application form which you can request from the Reception Team.

For security purposes, you must prove your identity to the Reception Team when you **collect** your username and password.

Any patient aged **16 and over** needs to complete and sign an application form.

A parent or guardian can apply for access to their childs records if they are aged **under 11**.

Between the ages of **11 and 15** a child can authorise their parent or guardian to have access on their behalf, or can apply for access in their own right.

If a patient would like access to another patients records (i.e. an elderly parent, or patient with a disability) please contact Paula Smith to discuss this on 01670 502337.

If you would like an application form, please ask the Reception Team who will be able to help.

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Summary Care Records / Care Data

Summary Care Records

Lintonville Medical Group has signed up to Summary Care Records. All patients in the Practice will have a Summary Care Record unless they opt out. If you would like any further information regarding Summary Care Records, please contact Reception. Opt-out forms are also available from Reception.

Care.data

Under the Health and Social Care Act 2012 the Health and Social Care Information Centre (HSCIC) on behalf of NHS England will be able to extract personal and identifiable information about all patients in England.

What you need to do:

If you are happy for NHS England to direct the HSCIC to extract, store and manage / use your personal information then you need do **nothing** as the information will be automatically taken from our clinical system.

If you don't wish your information to be extracted, then you **MUST** tick the box below and we will then block the uploading of your identifiable and personal information to the HSCIC.

□ I do not agree to the uploading of my identifiable and personal information to the HSCIC.

If you are happy for your information to be extracted and used by the HSCIC for anonymised reports but **NOT** shared by the HSCIC with other agencies or companies in identifiable format, please tick the box below.

□ I do not agree to the sharing of my identifiable and personal information by the HSCIC with other agencies or companies.

Print name: ………………………………….

DofB: ………………………………….

Signed: ………………………………….

Date: ………………………………….