A close-up of a logo

Description automatically generated

**NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE (ADULT)**

This information will remain strictly confidential. Please make sure you answer all questions and sign the form.

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **PLEASE COMPLETE IN BLOCK CAPITALS** |
| TITLE: MR/MRS/MISS/MS/DR/OTHER (please state) | SURNAME: |
| FORENAMES | DATE OF BIRTH |
| **MOBILE TELEPHONE NUMBER:**  You will automatically be sent a text reminder for appointments. Please tick the box if you wish to opt out of this service | |
| **EMAIL**  By providing an email address you agree to being contacted by the practice using this method.  Please tick the box if you wish to opt out of this service | |
| Have you ever been registered with the practice before?  Yes No | |
| **Allergies**: Please give details of any allergies or drug sensitivities you may have. | |
| **Specific Needs**: Do you have any specific needs that the Practice needs to be aware of e.g. sensory or physical disabilities, phobias, interpreter, religious or cultural requirements? (Please give details) | |

**Patient Online Services Registration Form**

* **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. Access can also be gained on some phones using fingerprints or Face ID – please consider this.**
* **If you have concerns about this, 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.**
* **The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone they feel it could harm or be put at risk.**

***Key considerations*** page2image1425567360

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

Having read the previous page, I would like to have access to the following GP online services (tick all that apply)

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| **If repeat prescriptions online access requested and you live more than one mile from a chemist you can collect your medication from our Dunster Surgery and this will be added to your nomination**  If you live within one mile of a chemist please nominate where you would like to collect your medication from:  Tesco, Minehead □ Boots, Minehead □ Alcombe Pharmacy □  Porlock Pharmacy □ Other □ please state…………………………………..  This information will be added to your notes and will be the primary chemist for you to collect your medication from. |  |
| Accessing my medical record |  |
| Sign up for SMS messaging and appointment reminders (mobile no, must be provided on the front page of this form) |  |

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

|  |  |
| --- | --- |
| I wish to access my medical record online and understand and agree with each statement (tick) |  |
| 1. I will be responsible for the security of the information that I see or download and I have read the information on the next page |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 5. 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. |  |

**The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

**Information about you: If you do not complete this information and have provided a mobile phone number we will send you a text when we register you to gather this information.**

|  |  |
| --- | --- |
| What is your: | |
| Height |  |
| Weight |  |
| If you have access to a blood pressure machine please provide an up to date reading: | |

|  |  |  |
| --- | --- | --- |
| What is your current smoking status | | |
| Never smoked | Ex smoker | Current smoker |
| If current smoker or ex-smoker how many cigarettes or  ounces of tobacco do you/did you smoke per day? | |  |
| Would you like some help to stop smoking? | | Yes/No |
| If you are an ex-smoker, what year did you cease  smoking | |  |

|  |  |  |
| --- | --- | --- |
| Do any of your family members have the following chronic diseases | | |
|  | | |
| Chronic disease | Age at diagnosis | Family member |
| Diabetes |  |  |
| Heart Disease |  |  |
| Stroke |  |  |
|  |  |  |
|  |  |  |

**Do you drink alcohol? Yes/No**

A comparison of a drink

Description automatically generated with medium confidence

If Yes,

How often do you have an alcoholic drink? (circle your answer)

Never Monthly 2-4 times 2-3 times 4+ times

or less per month per week per week

How many units of alcohol do you drink on a typical day when you are drinking? (circle

your answer)

1-2 3-4 5-6 7-9 10+

How often have you had 6 or more units if female, or 8 or more units if male, on a single

occasion in the last year? (circle your answer)

Never Less than Monthly Weekly Daily or

Monthly almost daily

|  |
| --- |
| **CHOICES ABOUT SHARING YOUR INFORMATION** |
| **Summary Care Record (SCR):**  You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. Your options are outlined below; please indicate your choice by ticking the appropriate box:  **Express consent for medication, allergies and adverse reactions only**. You wish to share  information about medication, allergies for adverse reactions only.  **Express consent for medication, allergies, adverse reactions and additional information.** You wish to  share information about medication, allergies for adverse reactions and further medical information  that includes: your illnesses and health problems, operations and vaccinations you have had in the  past, how you would like to be treated (such as where you would prefer to receive care), what  support you might need and who should be contacted for more information about you.  **Express dissent for Summary Care Record (opt out).** Select this option, if you DO NOT want any  information shared with other healthcare professionals involved in your care.  ***If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.*** |
| **Carers and those with carers** |
| Dunster and Porlock Surgeries keeps a register of patients who either care for an elderly, infirm or disabled relative or friend or those patients who require the help of a relative or friend, to enable us to offer appropriate help and advice. Please tick the appropriate box. |
| I am the main carer for an elderly, infirm or disabled relative or friend. What help do you give? |
| I rely on the help of a friend or relative to enable me to continue living at home. What assistance do you receive? |
| Name of your carer or the person you care for: |

|  |  |
| --- | --- |
| **Consent to authorise another person to receive medical information on your behalf**  If you want us to be able to give information to a relative, friend or carer please complete the form below. | |
| **Details of person to be given access to this Patient’s information:** | |
| Full Name |  |
| Address and contact number(s) |  |
| Relationship to you |  |
| If more than one person is to be given access please list below additional name and contact details: | |
| If the above named is not your next kin please provide your next of kin details below (this information will be solely for Practice use and will not be used to give them access to your medical records). | |
| Full Name |  |
| Address and contact number(s) |  |
| Relationship to you |  |

**Ethnicity**

|  |
| --- |
| White British White Irish White Other Black African Black  Indian Pakistani Bangladeshi Chinese Other  (please state) ---------------------------------------  English Other (please state)  --------------------------------------------  **WILL YOU NEED AN INTERPRETER YES / NO** |

|  |  |
| --- | --- |
| You are free to change your decision regarding your consent choices at any time by informing your GP practice.  Signature ……………………………………………………………….. Date ………………………………….  Signed by patient Signed on behalf of patient  PRACTICE USE ONLY | |
| Registration received by | Date |
| ID seen | Registration data entered by |
| Online registration authorised | Date |