|  |  |  |  |
| --- | --- | --- | --- |
| Title | Surname/Family NameBALSALL COMMON & MERIDEN GROUP PRACTICEConfidential New Patient Questionnaire (16+) | Given Name | Middle Names |
| Marital status | Previous surnames | Name known as | Date of Birth |
| House Name or Number | Street | Area |
| Postcode | Home Telephone No |
| Work Telephone No | Mobile | Email: |

|  |  |
| --- | --- |
| Occupation |  |

|  |  |
| --- | --- |
| Next of Kin |  |
| Full Name |  |
| Relationship |  |
| AddressHouse Name andNumberStreetTownPost Code |  |
| Contact Telephone Number |  |

This Practice uses text messaging for Practice appointment reminders, Practice news or advice about your health and Group reminders (eg Flu vaccine).

I DO/DO NOT wish to be contacted via text message (Please delete as appropriate)

Signed...……………………………………………………………….. Date……………………………………….

Please note in order to maintain confidentiality, it is your responsibility to contact the Practice and update any changes to your mobile number. If you wish to opt out of receiving text messages at any time, please contact us.

|  |
| --- |
| Who is a Carer? A Carer is someone, who, with or without payment, provides help & support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to being elderly, have a physical or mental illness, addiction or disability. We would be grateful if you could complete the boxes below to ensure we can offer you (if you are a Carer) or your Carer the correct help & support |
| Are you a Carer? Yes/No | If yes, for whom? |
| Do you have a Carer? Yes/no | Name of Carer |
| Address & Contact Details for Carer |  |
| Signed/ Agreed by Patient |  |
| Allergies – We especially need to know of any *drug allergies* and the effect they have had on you, please include non-drug allergies if they have a significant effect on your health.……………………………………………………………………………………………………………………………………………………… |

|  |  |
| --- | --- |
| Your Height | Your Weight |

|  |
| --- |
| Diet: Please indicate which option best describes your usual diet |
| Poor | Average | Good | Special Diet (Please give details) |

|  |
| --- |
| Exercise: Please indicate which option best describes your exercise regime |
| Light | Moderate | Heavy | Avoid it | Own health prevents it |

Medication

Please note – if you are on regular medication please make an appointment with a doctor before your next prescription is due, and bring with you your current medication repeat slips or boxes / bottles of your medications. If you use an asthma inhaler please make an appointment with the asthma nurse.

Operations and Past Medical History

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| Do you Smoke?Yes/No | If Yes how many | Have you ever smoked?Yes/No | When did you give up? |
| If you would like support to stop please make an appointment with a Practice Nurse. |

Units of Alcohol

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 UNIT | 1.5 UNITS | 2 UNITS | 3 UNITS | 9 UNITS | 30 UNITS |
|  |  |  |  |  |  |
|  |  |  |  |  |
|  |

|  |  |  |
| --- | --- | --- |
| Alcohol Consumption: | Please circle appropriate answer. | Scores:to be completed by the surgery |
| 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 units on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Scoring (for practice use) | 0 | 1 | 2 | 3 | 4 |  |

A total of 5+ indicates increasing or higher risk drinking
An overall total score of 5 or more is AUDIT C positive. **Read code 38d4**

Total score:

|  |  |  |
| --- | --- | --- |
| Alcohol Consumption | Please circle the appropriate answer. | Scores:To be completed by the surgery |
| 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 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 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? |  |  |  |  |  |  |
| Scoring (for practice use) | 0 | 1 | 2 | 3 | 4 |  |

**Total score equals score above+ audit C Read code 38D3**

Total score:

Scoring: 0 - 7 Lower risk, 8 – 15 increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

We have been asked by the NHS to collate ethnic origin details of new patients registering at the practice.

**Please tick ONE box which indicates your ethnic origin.**

It is not compulsory to complete this form, although knowledge of your origins may help in early diagnosis of some conditions more common in specific communities.

Name……………………………………………………………………….. Date of Birth…………………………..

White

[ ] British
 [ ] Irish
 [ ] Any other background please specify below
 ………………………………………………………………………..

Mixed

[ ] White and Black Caribbean
 [ ] White and Black African
 [ ] White and Asian
 [ ] Any other background please specify below
 ………………………………………………………………………..

Asian

[ ] Indian
 [ ] Pakistani
 [ ] Bangladeshi
 [ ] Any other background please specify below
 ………………………………………………………………………….

Black or Black British

 [ ] Caribbean
 [ ] African
 [ ] Any other background please specify below
 ………………………………………………………………………….

First Language

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

Religion

…………………………………………………………………………………………………………………

For further information about the Practice, please see the Practice leaflet or visit our website

[www.balsallcommongrouppractice.co.uk](http://www.balsallcommongrouppractice.co.uk)

**Register your Type 1 Opt-out preference**

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: <https://www.nhs.uk/your-nhs-data-matters/>

You can use this form to:

* register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
* withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

### This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

**Details of the patient**

|  |  |
| --- | --- |
| **Title** |  |
| **Forename(s)** |  |
| **Surname** |  |
| **Address** |  |
| **Phone number** |  |
| **Date of birth** |  |
| **NHS Number (if known)** |  |  |  |  |  |  |  |  |  |  |

**Details of parent or legal guardian**

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Relationship to patient** |  |

#### Your decision

**Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes except their own care.

**Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

### **Your declaration**

I confirm that:

* the information I have given in this form is correct
* I am the parent or legal guardian of the dependent person I am making a choice for set out above (if applicable)

**Signature**

**Date signed**

**When complete, please post or send by email to your GP practice**

----------------------------------------------------------------------------------------------------------------

**For GP Practice Use Only**

|  |  |
| --- | --- |
| Date received |  |
| Date applied |  |
| Tick to select the codes applied | **Opt – Out - Dissent code:**9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|)  |  |
|  | **Opt – In - Dissent withdrawal code:**9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)] |  |

BALSALL COMMON AND MERIDEN GROUP PRACTICE

**Information for new patients: about your Summary Care Record**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

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 on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.
3. **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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

……………………………