STATION ROAD SURGERY
69 STATION ROAD, SIDCUP

NEW PATIENT INFORMATION

We would like to take this opportunity to welcome you to Station Road Surgery.

In order to register with the Surgery you will need to complete the attached forms:

1. GMS1 Form (purple form) signed and dated as appropriate.
2. New Patient Questionnaire (2 pages).
3. FAST Questionnaire.

We also require production of the following documents:

1. Photo ID – passport or driving licence.
2. Proof of residence – Utility Bill/Bank Statement/Tenancy Agreement (any of which must have your name and address you wish to register from).

For each child UNDER 5 please also complete a New Patient Immunisation Form.

Once you are registered please book a double appointment with our Healthcare Assistant for a new patient health check.

The Practice offers a wide range of services including travel immunisations and advice, child immunisations etc.

Every September/October we recommend influenza vaccinations for all our elderly over 65 patients and those suffering from any chronic conditions. Please note: reminders are no longer sent out in the post.

If you have repeat prescriptions, please attach a copy to your application.

ALL PATIENTS AREALLOCATED TO A GP AS FOLLOWS:
A-C & Q-S Dr Elsey. D-I & T-V Dr Money. J-P & W-Z Dr Knigge.
HOWEVER IT DOES NOT MEAN THAT YOU HAVE TO SEE THIS DOCTOR.

YOU WILL BE ABLE TO MAKE AN APPOINTMENT ONCE YOU ARE REGISTERED

STATION ROAD SURGERY
NEW PATIENT QUESTIONNAIRE

***** = **MUST** be completed

Date …….

*Surname …… *****Forenames ……

*****Date of Birth …… NHS No (if known) ……

*****Address ……

*****Postcode …… *****Telephone (home and mobile)……

Can we contact you by e-mail? (Please add address)……

Marital Status – single ☐ married ☐ divorced ☐ separated ☐ widowed ☐ other……

Occupation …… or Name of School/College ……

Who else lives at the same address (if registered here) ……

Do you have private health insurance? Please specify ……

*****Have you ever smoked? …… How many a day? …… If stopped, when ……

Smoking is bad for your health and if you would like to give up, the practice offers smoking cessation clinics to give you help and support. Please ask at reception for details about the clinics.

*****During an average week, how much alcohol do you drink? ……

Do you take any regular exercise? …… If yes, what type ……

*****What is your height? …… *****What is your weight? ……

*****If you would like advice and/or be tested for Sexually Transmitted Infections. Please tick Yes ☐ No ☐
If yes please make appointment with the practice nurse when you bring this form in to register

*****Which ethnic group do you consider you belong to? Please tick :

☐ White British ☐ White Irish ☐ White Other ☐ White & Black Caribbean
☐ White & Black African ☐ White and Asian ☐ Mixed other ☐ Other ethnic category
☐ Asian Bangladeshi ☐ Asian Indian ☐ Asian Other ☐ Asian Pakistani ☐ Chinese
☐ Black African ☐ Black Caribbean ☐ Other Black background

*****Main Language Spoken? …… Preferred Language? ……

*Preferred method of contact/communication? ……

Please list any major health problems, hospital admissions, operations :

Approximate Date	Nature of problem/illness/operation
……	……
……	……
……	……

Please list anything you are allergic or sensitive to (eg drugs/food/pollen etc) :

……

When, if ever, did you last have the following injections/are you up to date?

Polio? …… Tetanus? …… Travel?……

Please list the date of birth and names of any children

Date of Birth	Name
……	……
……	……
……	……

Please list any illnesses that have affected your close family eg. Heart disease/bp/diabetes etc :

……

……

Are you a Carer? Yes ☐ No ☐ Do you have a Carer? Yes ☐ No ☐ (Please add details below)

If Yes, Carers Details:

Name: …… Relationship: ……

Contact Details;

……

……

<u>WOMEN ONLY</u>

How many times, if ever, have you been pregnant? ……

When, if ever, did you last have a cervical smear test?(over 25s only)……

Where was it performed? …… Result? ……

If needed, what contraceptive method do you use? ……

Have you had a hysterectomy?/when?……

THANK YOU FOR YOUR CO-OPERATION

FAST QUESTIONNAIRE

Name: Date:

NHS No: DOB:

For the following questions please tick the answer which best applies.

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **4**
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **4**
How often during the last year have you failed to do what was normally expected of you because of drinking?	**Never** ☐ **0**	**Less than monthly** ☐ **1**	**Monthly** ☐ **2**	**Weekly** ☐ **3**	**Daily or almost daily** ☐ **4**
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	**No** ☐ **0**	**Yes, on one occasion** ☐ **2**	**Yes, on more than one occasion** ☐ **4**		
Total for Each Column:	_	_	_	_	_

TOTAL:

======

Patient Services - Patient registration form

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Please note:

- **You will be emailed your Vision online token which you will need to register for this service.**
- **Patient Services is ONLY available for patients over the age of 16.**
- **All applicants MUST use a private, sole use email address to protect confidential information.**

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Date of birth	D D / M M / Y Y Y Y
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	D D / M M / Y Y Y Y
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	D D / M M / Y Y Y Y

Staff use only	
Type of ID	
Staff name	
Date	D D / M M / Y Y Y Y

About Vision online services

About Patient Services

We offer an online service for our patients so you can book your appointments, order your repeat prescriptions and have online access to your medication history and allergies online at your convenience.

Online appointment booking

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don't need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

Request your repeat prescriptions online

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

Access to your GP record online

Take greater control of your health and wellbeing by being able to view your medication history, allergies and adverse reactions online.

Information for new patients: about your Summary Care Record

Dear Patient,
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.

- **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.

Once you have completed 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: ……

Date of Birth: …… Patient's Postcode: ……

Surgery Name: …… Surgery Location (Town): ……

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://systems.digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below;

Summary Care Record Consent Preference	Read 2	CTV3
The patient wants a core Summary Care Record (Express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (Express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (Express dissent for Summary Care Record (opt out)	9Ndo.	XaXj6