|  |  |
| --- | --- |
|  | WESTERN ROAD MEDICAL CENTRE  Dr N Leigh-Collyer Dr S L Bond Dr A Dhairyawan  Dr I Quigley Dr S Awan Dr Y Heerah Dr P Agarwal  99 Western Road, Romford, Essex. RM1 3LS  Tel: 01708 775 300 Fax: 01708 737 936  [www.westernroad.co.uk](http://www.westernroad.co.uk/)  [HAVCCG.westernroad@NHS.net](mailto:HAVCCG.westernroad@NHS.net) |
|  |  |

Thank you for choosing Western Road Medical Centre.

|  |
| --- |
| IMPORTANT INFORMATION: PLEASE READ CAREFULLY |

* We can take Registration applications **Tuesday, Wednesday and Thursday**. We ask you to be considerate to patients with appointments as it can be very busy and we advise you to come at less busy times such as lunchtime after morning surgery and before 6:45 pm.
* To be a member of Western Road you need to live in the catchment area, our area covers parts of RM1, RM11 and all of RM2 only. Use the link on our website or ask at reception to check if your address is covered.
* Patients under 16 years will need to provide a PHOTOCOPY of their full birth certificate and immunisation history (Red book). Overseas immunisations may need to be translated.
* If your application is successful, any new patients up to the age of 16 years, or patients of any age with long term health conditions should arrange an appointment with a practice nurse for a new patient health check.
* If you do not complete all of the Registration process your papers may be sent back to your home address or left at reception for you to pick up. We reserve the right to refuse uncompleted forms or patients outside of our catchment area.

**Please see below a list of required documents that the practice must see before we can register you. The Practice will need you to supply photocopies, and you will also need to show the originals to a receptionist to verify documents when handing in your paperwork.**

|  |
| --- |
| DOCUMENTS REQUIRED FOR REGISTRATION WITH WESTERN ROAD MEDICAL CENTRE  All Patients are asked for previous NHS number if available.  **British Citizens:**   1. Proof of identity: passport/birth certificate/driving license 2. Proof of address: i.e. current domestic bill from Havering Council/gas/electric/water/bank accounts or tenancy agreement/mortgage/ownership agreement – this needs to be dated within 3 months of applying We do not accept mobile phone bills or invoices.   **EU Residents:**   1. **Passport/ID Card** 2. **Date of entry to UK** 3. **Proof of Address:** i.e. current domestic bill from Havering Council/gas/electric/water/bank accounts or tenancy agreement/mortgage/ownership agreement – this needs to be dated within 3 months of applying   **Patients from abroad excluding EU members:**   1. **Passport** 2. **Valid Visa/Residence Permit** – with UK status – student visa must be accompanied by college confirmation 3. **Proof of date of entry into the UK** 4. **Proof of address:** i.e. current domestic bill from Havering Council/gas/electric/water/bank accounts or tenancy agreement/mortgage/ownership agreement – this needs to be dated within 3 months of applying |

**Patient Information**

***GP ONLINE SERVICES:*** *The Practice also offers patients access to* ***GP ONLINE SERVICES*** *if you are interested in this service please speak to a receptionist who will provide you with a consent form to complete, you will also require two forms of id one of which needs to be photo id. The practice will then provide you with a Registration Letter with the details required for you to sign up/register with patient services online.*

***GP ONLINE SERVICES:*** *provides patients with online access book appointments, ordering repeat prescriptions and by the 31st of March 2016, access to detailed coded information (DCR) held in patients’ records*. (This is an additional service available for patients. Please contact the surgery for more information.)

**Prescriptions:** The prescription enquiry phone line is open between 10:00 am until 12:00 noon and 4:00 pm until 6:00 pm. Please note that we cannot take orders for prescription over the telephone. Prescriptions can be ordered in writing and placed in the box in reception and will be ready to pick up in 48 hours.

*Alternatively:*

**Electronic Prescriptions Service (EPS):** We can now electronically send your repeat prescription to a pharmacy of your choice. This will save you a trip to the surgery to collect it, as it will be send directly to your chosen pharmacy ready for you to collect. To sign up to this service, please complete the form on our website homepage or ask at reception.

You can contact the surgery for **emergency appointments** from 8:30 am.

The surgery is open all day from 8:45 am until 7:00 pm Monday until Friday and telephone lines for all other enquiries are open from 8:30 am until 6:30 pm.

Secretaries are available most days between 8:30 am and 4:00 pm.

Patients can contact the Surgery between 4:00 pm and 6:00 pm to enquire about test results.

We have a strict policy for patients who **DO-NOT-ATTEND** appointments; you must contact the surgery to cancel your appointment if you cannot make your appointment.

**NEW PATIENT HEALTH CHECK**

As part of the registration process, if you come under one of the following groups please make an appointment to see our practice nurse.

* **Patients 0 to 16 years** – please make an appointment with a practice nurse from 10 days after your registration papers have been handed in. This is to give us time to administer your data onto our system and request your medical history from your previous GP. Please bring the following with you to this appointment:
  + Red Baby Book
  + All immunisation history
  + Current medications
  + Name of school
* **Any patient with long term health conditions or on regular prescribed medication** – please make an appointment with a practice nurse from 10 days after your registration papers have been handed in. Please bring with you all medication and any relevant medical history.

We ask that patients keep the Surgery informed of any changes to your contact details as you may be deducted from our Patient List if we **cannot** contact you by either post or telephone or if we receive Return to Sender letters back at the surgery.

We do our upmost to accept all patients from our catchment area. If you do not follow the registration process, you may be declined from the Surgery’s Patient list.

Western Road Medical Practice

New Patient Questionnaire

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname** |  | | | | **Forename** | | | | |  | | | | | |
| **DOB** |  | | | | **Marital Status** | | | | |  | | | | | |
| **Address** |  | | | | | | | | | | | | | | |
| **Post code** |  | | | | **Home** | | |  | | | | | | | |
| **Mobile** |  | | | | **Email** | | |  | | | | | | | |
| **NHS Number** |  | | | |
| **School/College \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | |
| **Are you happy to receive info from us by either text or email?**  **SMS text** YES NO  **Email** YES NO | | | | | | | | | | |  | | | |
| **Height** | |  | | | **Weight** | | | |  | | | | | |
| **Occupation** | |  | | | **Next of Kin/Parent/ Guardian** | | | |  | | | | | |
| **Relationship of next of kin/parent/ guardian** | |  | | | **Contact number**  **of next of kin/parent/guardian** | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **For children – 2nd parent/guardian name**  **Relationship**  **Contact Details** | | | | | | | | | | | | | | |
| **Is there anyone else registered at this practice you wish to be linked**  **to**? (your personal information will remain confidential – this will simply alert clinicians and admin about any personal connections between patients)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to you** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Past medical history**  Please tick or write “Y” next to any condition you have:  No known medical problems? Yes No  If Yes to last question, please tick/mark “Y” all that apply and give further details below:  Asthma | | | | | | | | | | | | | | |
| COPD  Diabetes  High blood pressure  High cholesterol  Heart Attack  Stroke/TIA  Cancer  Epilepsy  Peripheral Vascular Disease  Learning Difficulties  Mental Health Problems  Dementia  Thyroid disease  Kidney disease  Liver disease  Blood disorder  Previous operations  Other not listed above  Please give further details below: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Please list all prescribed or self-purchased medication you are currently taking:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Are you or your child known to any other services? (e.g. social services etc)**  **Are you/your child a carer for anyone?** YES NO | | | | | | | | | | | | | | |
| **Are you permanently housebound?** YES NO  **Carers consent** | | | | | | | | | | | | | | |
| If you have a carer (or someone else) who you would give consent to access your medical information, please complete the following section:  Name of carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Consent:  I give permission for my carer (as named above) to have access to my medical records and personal details (including verbal discussions and written records/ reports) held by the practice (delete as appropriate)  Yes No  This permission relates to (please circle or mark “Y” as appropriate):  All of my records  Part of my records  If part of records, please specify which aspects you consent for your carer to have access to:  Please specify if any information you do not wish to be disclosed:  I understand that the health care professional (doctor/nurse) may override this authority at any time and this permission will remain in force until cancelled by me in writing.  Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Does someone hold Lasting Power of Attorney over your care?**  YES NO  If YES, please provide name, contact, and further information:  **Do you have an Advance Statement/Advanced Decision to Refuse Treatment?**  YES NO  If YES, please send us/attach a copy  **Do you have a Do Not Resuscitate order in place?**  YES NO  If YES, please send us/attach a copy | | | | | | | | | | | | | | |
|  | | |  | | | |  | | | | |  | | |
|  | | |  | | | |
| **We need to know your alcohol intake**  How often do you have a drink containing alcohol? (Please tick the correct answer) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Never | | | |  | | How often do you have 6 drinks or more on one occasion? | | | | | | | Never |  | |
| Daily | | | |  | | Monthly |  | |
| Weekly | | | |  | | Weekly |  | |
| Monthly or Less | | | |  | | Daily |  | |
| Ex-Drinker | | | |  | | **UNITS PER WEEK** | | | | | | |  | | |
|  | | | | | | | | | | | | | | | |
| **What best describes the amount of exercise you do?** | | | | | | | | | | | | | | | |
| Inactive | | | |  | | Gentle | | | | | | | |  | |
| Moderate | | | |  | | Vigorous | | | | | | | |  | |
|  | | | | | | | | | | | | | | | |
| **Which of the following best describes your diet?** | | | | | | | | | | | | | | | |
| Good | | | |  | | Poor | | | | | | | |  | |
| Vegetarian | | | |  | | Vegan | | | | | | | |  | |
| Specialist (please specify) | | | |  | | | | | | | | | | | |
| **We need to know your smoking history** | | | | | | | | | | | | | | | |
| Never smoked | | | |  | | Ex-smoker | | | | | | | |  | |
| Smoker | | | |  | | If so, how many per day? | | | | | | |  | | |
| **Women ONLY** | | | | | | | | | | | | | | | |
| ARE YOU PREGNANT? | | | |  | | Expected delivery date | | | | | | |  | | |
| *If yes, please make an appointment to see a doctor for your ante-natal referral* | | | | | | | | | | | | | | | |
| When was your last Smear test? | | | |  | | | | | | | | |  |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please indicate your ethnic origin. This is not compulsory but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions. | | | | | | | |
| **Ethnic Origin** Please tick one of the following | | | | | | | |
| White British | |  | Greek | | | |  |
| White Irish | |  | Greek Cypriot | | | |  |
| White Scottish | |  | Turkish | | | |  |
| White Welsh | |  | Turkish Cypriot | | | |  |
| Black Caribbean | |  | Italian | | | |  |
| Black African | |  | Polish | | | |  |
| Black British | |  | Kosovan | | | |  |
| Black West Indian | |  | Albanian | | | |  |
| Black Guyana | |  | Bosnian | | | |  |
| Black North African | |  | Croatian | | | |  |
| Black Arab | |  | Serbian | | | |  |
| Black Iranian | |  | Other republic of Yugoslavia | | | |  |
| Black – other African country | |  | Sri Lankan | | | |  |
| Black East African Asian | |  | Israeli | | | |  |
| Black Indo-Caribbean | |  | Kurdish | | | |  |
| Black other Asian | |  | Moroccan | | | |  |
| Black other mixed | |  | Mauritian | | | |  |
| Vietnamese | |  | Romanian | | | |  |
| Indian | |  | Other | | | |  |
| Pakistani | |  |  | | | |  |
| Bangladeshi | |  |  | | | |  |
| Chinese | |  | I do not wish to give my ethnicity | | | |  |
| What is your first spoken language? | | | |  | | | |
| If English is not your first language, can you speak English? | | | |  | | | |
| Patient Signature |  | | | | Date |  | |

**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 who 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, ifyou **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 adversereactions.

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.

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**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: ………….........................................................................................................

|  |  |  |
| --- | --- | --- |
| Parent | Legal Guardian | Lasting power of attorney |
|  |  | for health and welfare |

**Please circle one:**

For more information, please visit [https://www.digital.nhs.uk/summary-care-records/patients,](https://www.digital.nhs.uk/summary-care-records/patients) call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

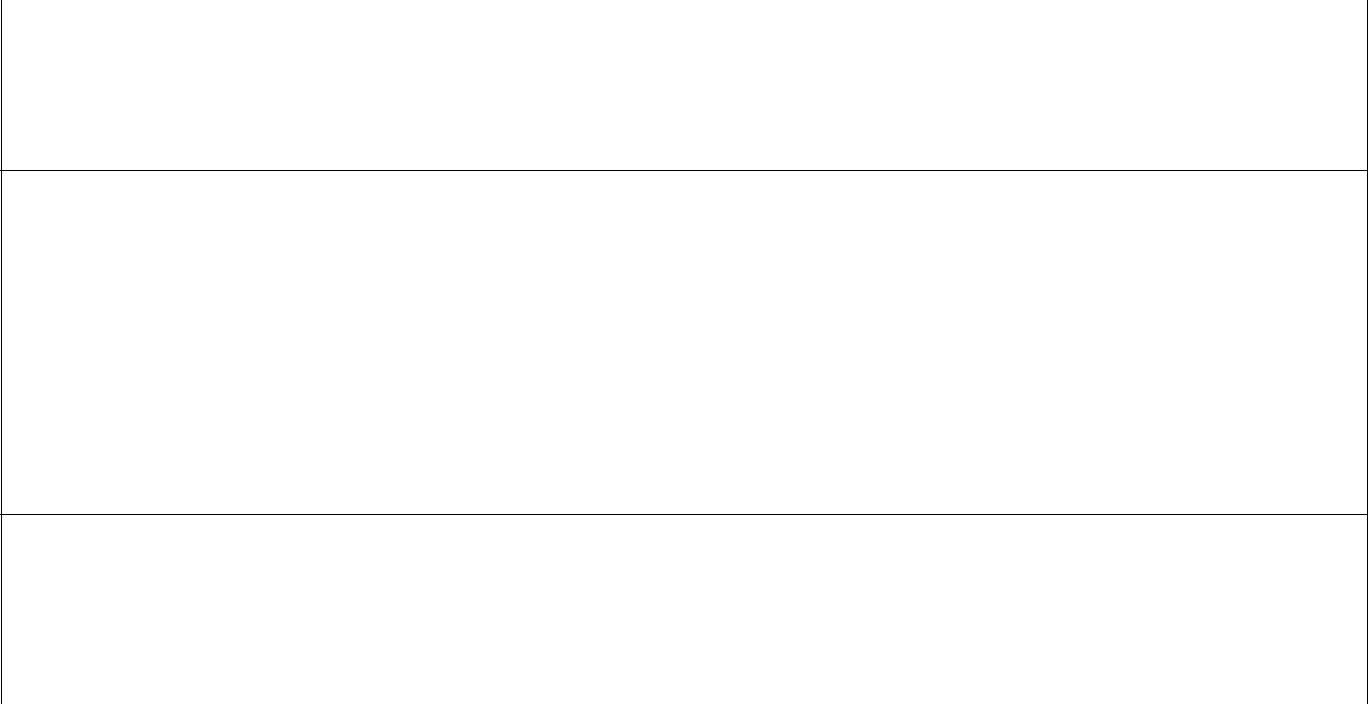
To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

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

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*Application for online patient services*



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 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 |  |  |
|  |  |

I wish to have access to online patient services and understand and agree with each statement (ticked below)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3. | | I will be responsible for the security of the information that I see or download | | | | |  |  |
|  |  |
| 4. | | If I choose to share my information with anyone else, this is at my own risk | | | | |  |  |
|  |  |
| 5. | | I will contact the practice as soon as possible if I suspect that my account | | | | |  |  |
|  |  | has been accessed by someone without my agreement | | |  |  |  |  |
|  |  |  |  |  |  |
| 6. | | If I see information in my record that is not about me or is inaccurate, I will | | | | |  |  |
|  |  | contact the practice as soon as possible | | |  |  |  |  |
|  |  |  |  |  |  |
|  |  | | |  |  | |  |  |
|  | Signature | | |  | Date | |  |  |
|  |  |  |  |  |  |  |  |  |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number or EMIS no: | | Method | |
|  |  |  | Vouching  |
|  |  | Vouching with information in record  | |
| Identity verified by | Date |  |  |
| (initials) |  | Photo ID and proof of residence  | |
|  |  | Please state ID type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |  |
| Authorised by |  |  | Date |
|  |  |  |  |