Registration Admin Notes:

Welcome to
WEST MOORS GROUP PRACTICE

175 Station Road West Moors BH22 0HZ
Telephone 01202 865800

NEW PATIENT QUESTIONNAIRE

When returning your completed form/s you will need to bring in photographic proof of identification, e.g. passport or driving licence. Please also bring in original documents to provide identification of your address, i.e. utility bill.

Parents of patients under age 16 are required to show the child's birth certificate or passport – babies born in RBH or PH of patients registered at the practice can be verified from the maternity discharge summary.

Are you a patient who is not ordinarily resident in the UK? Please ensure you complete the reverse of the GMS1 form.

On registration you will be allocated a named GP, to find out who this is please contact the Practice 21 days after registering. If you have a preference as to who your named GP is, we will make reasonable efforts to accommodate your request. Please remember that although your named GP is responsible for your overall care, you are still able to see any GP of your preference.

Patient: I confirm that the information I have provided is true to the best of my knowledge:

Signature of Patient	Signature on behalf of Patient	Date:
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Print Name:	Print Name:	
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Reception Only:

Photo ID Type: _____ Seen by: _____ Date: _____

Address ID Type: _____ Seen by: _____ Date: _____

Communication with You

Please complete as many of the following as are applicable to you:

Home Telephone:	Mobile Telephone:
Work Telephone:	Fax Number:
Email Address:	
Letter to home address as detailed on page one.	
Letter to other correspondence address, please write address here:	

Please indicate your preferred communication method by circling one of the above.

The practice aims to ensure that disabled people have the communication support they need. If you would like this form or information – and subsequent information – sent to you in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know.

Please select the format that would suit you best:

Braille:	Large Print:
Audio Tape:	Easy Read:
British Sign Language: Other Sign Language:	Other: Please Specify:

If you have a carer does this person need to specify a preferred method of communication and/or an alternative communication format? Please advise their contact details on the Carers Information box on page two of the registration forms and write their name above where applicable. If you are a parent or guardian of a patient and you would like to specify a preferred method of communication and/or an alternative communication format, please let us know.

Please note: It is your responsibility to ensure the above information is kept up to date on our records and that when used the method of communication is secure for patient confidential information.

Emergency contact information Please advise of a contact outside your household, if possible.

Name: Title/Given Name/Family Name: _____

Gender: _____ Relationship to patient: _____

Telephone Numbers: Mobile/Landline: _____

Is this person your **NEXT OF KIN**? If not, please advise your next of kin:

Name: Title/Given Name/Family Name: _____

Gender: _____ Relationship to patient: _____

Telephone Numbers: Mobile/Landline: _____

CARERS INFORMATION

1. Full Name of Carer: _____

2. Telephone: Home: _____ Mobile: _____

3. Full Name of person being cared for: _____

Address of person being cared for *(if different from Carers address)*

_____

_____

4. Relationship of carer to person being cared for:

Mother / Father / Son / Daughter / Spouse / Other:

5. Reason why caring is required: _____

CONSENT - FOR USE OF SMS TEXTING

*To **Opt Out** of Receiving Appointment Reminders by SMS Text Message*

We would like to use our SMS text reminder service to send you a reminder via your mobile phone approximately 24 hours before your appointment is due.

If you would **NOT** like to use this service please sign and date below:

Signature: _____ Date: _____

ELECTRONIC PRESCRIPTION SERVICE

The Electronic Prescription Service (EPS) is an NHS Service. It gives you the chance to change how your GP authorises your prescription.

If you currently collect your repeat prescription from your GP you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to our local pharmacy Moors Pharmacy, or you can designate a pharmacy of your choice. You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive. To authorise this process, please sign and date below - if this is not Moors, please advise the pharmacy name and address.

Note: Patients who live in a BH21 post code (other than NHs/CHs) are dispensed to from the Three Legged Cross branch surgery

Signature: _____ Date: _____

Pharmacy Name-Address: _____

WHICH ETHNIC BACKGROUND DO YOU REPRESENT:		
White British	White Irish	Any Other Ethnic Group
Mixed White & Black Caribbean	Mixed White & Black African	Mixed White & Asian
Asian or Asian British Indian	Asian or Asian British Pakistani	Asian or Asian British Bangladeshi
Black or Black British Caribbean	Black or Black British African	Chinese
First spoken language:	Do you need an interpreter? **Y/N**	

YOUR DETAILS

How tall are you?

ft in *or* centimetres

What do you weigh?

st lbs *or* kilos

REGULAR MEDICATION

Regular Medication: If you take regular medication, **please make an appointment to see a GP** bringing with you your repeat prescription details from your previous practice.

ALLERGIES - SENSITIVITIES

Are you allergic to any medication? (*If so please state)*

WEST MOORS GROUP PRACTICE
SYSTMONLINE – PATIENTS AGED UNDER 16 YEARS

SystmOnline is a 24 hour online access service that can be used day or night. With SystmOnline a patient under 16 years, or a representative of the patient, will be able to book and cancel appointments, and request prescriptions for repeat medication.

Child currently under the age of 11 years old
Online access for managing repeat prescriptions and appointments will be given to a parent/carer signing below. Parent/carer access will be reviewed and updated when the child is 11 years old.

Child currently aged 11-15 years old
Online access for managing repeat prescriptions and appointments can be requested by the parent/carer with the child's consent or by the child with parental/carer consent. Access can be given to the child without parental/carer consent at the discretion of his/her GP - please note this GP has to be familiar with the child in order to grant this request.

We are obliged to check identity – birth certificate or passport and proof of address – before accepting SystmOnline registration requests. Once ID has been verified, the account confirmed and the PIN document forwarded, registration will be enabled to register to access these details.

I WISH TO REGISTER THIS PATIENT FOR SYSTMONLINE TO ENABLE THE FACILITY TO BOOK AND CANCEL APPOINTMENTS and to REQUEST PRESCRIPTIONS FOR REPEAT MEDICATION.

Patient Name: _____ Patient Date of Birth: _____

Name of person registering patient: _____ Signed: _____

Email address: _____

Relationship to Patient: _____

Address: _____

CHILD CURRENTLY AGED 11-15 YEARS OLD – please sign (1) or (2)

(1) I give consent for the person named above to use online access to request repeat medication and book/cancel appointments for me:

Name: _____ Signed: _____ Address: _____

(2) I wish to apply to manage my own online access. I understand that if my parent/carer has not given consent by signing above, this requires the agreement of my GP:

Name: _____ Signed: _____ Address: _____

Reception Only: Age: _____

Passport or Birth Cert Seen by: _____ Date: _____

Address ID seen by: _____ Date: _____

WEST MOORS GROUP PRACTICE

SUMMARY CARE RECORD SHARING AND SYSTMONE RECORD SHARING

We strongly recommend that you allow other health professionals to access your medical record. The benefits to your care are immense:
Your Clinician will have a complete view of your medical history allowing accurate decisions to be made.
You will not have to explain your medical history countless times.
Your care will improve and unnecessary tests can be avoided.

Please complete the information below with your choices on sharing your data and hand to Reception:

Name: _____ **Date of birth:** _____

Signature: _____**Date:** _____

If you are filling out this form on behalf of another person or a child, their GP will consider this request. Please ensure you fill out their details above and your details below:

Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

Sharing using Summary Care Record Please tick one option:

I agree to a Summary Care Record containing details of my medications, allergies, and any bad reactions to medication. ☐

I agree to a Summary Care Record containing details of my medications, allergies, any bad reactions to medication AND any additional information useful for my care. ☐

I do not want to have a Summary Care Record (opt out). ☐

Sharing using SystmOne GP Clinical System Please tick one option:

I agree to sharing my data on SystmOne for my direct care ☐

Please state your email address and mobile telephone number below to enable us to send you a security code when another organisation wishes to view your information on SystmOne:

Please write both clearly so the correct information is entered on the patient record.

Email address:
_____

Mobile telephone number:
_____

I do not agree to the sharing of my information on SystmOne for the purposes of my direct care ☐