**MOORE STREET SURGERY**

**NEW PATIENT REGISTRATION**

Welcome to Moore Street Surgery. In order to register with this surgery we require you to complete form GMS1 and a New Patient Information form. Please complete these and hand them to the receptionist. We aim to process your application within 3 working days but this may take longer in some instances.

Please help us by providing evidence of medication that you are taking i.e. Right hand side of prescription, medication boxes or print out from previous GP. These must have your name for identification purposes.

We will ask for the following forms of identification:

* photo identity, such as your passport or driving license
* proof of your address, such as a recent council tax bill or utility bill (a gas, electricity, water or phone bill)
* If you are registering a child please bring your child’s birth certificate and proof of their address also and their Red immunisations book.

If you would like more information about registering with a GP please log on to [www.nhs.uk](http://www.nhs.uk)

When you have been registered with the practice we would like to invite you to participate in a new patient health check. Please ask the receptionist to make you an appointment. This health check will enable us to record some lifestyle information, blood pressure, height, weight etc. and give you relevant advice on how to stay healthy.

**When you hand in your questionnaire into us, we will ask you if you would like to register for Online Access. This will enable you to book and cancel appointments and order repeat prescriptions from any location with internet access.**

**Moore Street Surgery**

**New Patient Health Questionnaire for Adults**

**Your contact details**

Title Mr / Mrs / Miss / Ms /

Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_ First Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Name/House Number \_\_\_\_\_\_\_ Home Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information about you**

What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your first language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need an interpreter? Yes / No

**Ethnic Group**

White British Irish Other please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black Caribbean African Other Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian Indian Pakistani Chinese

Other Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mixed White + Black Caribbean

White + Black African

White + Asian

Other please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever served in the British armed forces? Yes No

If yes in what year did you leave the British armed forces?

**Religion**

Church of England Christianity Buddhism Jehovah’s Witness

Roman Catholic Sikhism Hinduism Islam

Other religion please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous GP**

Name and Address of Previous GP

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| --- |
|  |

**Medical Information**

Please list any serious illnesses/operations/accidents/disabilities (for women any pregnancy related problems, and the year they took place.

|  |
| --- |
|  |

Have you suffered from? (tick as appropriate)

Epilepsy Yes /No Blindness/Glaucoma Yes /No

High Blood Pressure Yes /No Diabetes Yes /No

Heart Attack/Stroke Yes /No Cancer Yes /No

Asthma Yes /No Eczema/Hay Fever Yes /No

COPD Yes /No

If yes please state the year when you were first diagnosed

|  |
| --- |
|  |

Please list the strength, dose and daily amount of any medicines being taken:

|  |
| --- |
|  |

**If you have a nominated pharmacy for electronic prescriptions, this is automatically carried across. If you wish to change your nominated chemist, you must let your new chosen pharmacy know.**

Are you disabled? (if yes, please give details) Yes / No

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| --- |
|  |

Are you allergic to any medicines and if so which? Yes / No

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| --- |
|  |

Have you ever refused treatment/screening of any kind and if so, what and when? Yes / No

|  |
| --- |
|  |

Have you ever suffered from? (tick as appropriate)

Anxiety Yes / No Depression Yes / No

OCD Yes / No Bipolar Disorder Yes / No

Substance Misuse Yes / No

If yes to any of these, please state the year when you were first diagnosed?

|  |
| --- |
|  |

Do you have any other mental health issues? (if yes please give details)

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| --- |
|  |

Are you receiving or have you received any mental health treatment or therapy?

(if yes please give details of your care and when you received it)

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| --- |
|  |

**Carers**

Do you have a carer? (if yes please give details including their name and Date of Birth) Yes / No

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| --- |
|  |

Are you a carer? (if yes please give details including their name and Date of Birth) Yes / No

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| --- |
|  |

**Women**

Have you ever had a cervical smear? (if yes please state when, where and the result) Yes / No

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| --- |
|  |

Have you ever had breast screening ( if yes please state when and the result) Yes / No

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| --- |
|  |

**Smoking**

Do you smoke? Yes / No

If so how many cigarettes do you smoke a day?

If ‘No’ have you ever smoked? Yes / No

If you are an ex-smoker, how many cigarettes or ounces of tobacco did you smoke per day?

Would you like advice on giving up smoking? If yes the number for SmokeFree Liverpool is 0800 061 4212 or 0151 374 2535.

**Alcohol**

**Please try and answer the questions below or we can help you fill this in when you come to see us.**

Are you teetotal? YES / NO

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits

How many units do you estimate that you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often did you have a drink containing alcohol in the past year? (please tick)

Never Monthly or less 2-4 times a month

2-3 times per week 4+ times per week

1. How many standard units did you have on a typical day when you were drinking in the past year?

1 or 2 3 to 4 5 to 6 7 to 9 10 or more

1. How often did you have 6 or more standard units on one occasion in the past year?

Never Less than monthly Monthly

Weekly Daily or almost daily

**Physical Activity**

|  |  |
| --- | --- |
| Think about what **activities** you do in a typical week that make you more out-of-breath than normal . This might be brisk walking; gardening; cycling; sport such as football or going to the gym. | |
| How many days per week do you usually do any of these activities? |  |
| How much time each day do you spend doing these activities? |  |

**Family History**

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure. Diabetes, or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

|  |
| --- |
|  |

**Next of Kin**

Please give name, address and telephone number of next of kin.

|  |
| --- |
| Name:  Contact Number:  Relationship:  Address: |

**For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)**

Have you had a flu vaccination? Yes / No . If yes please enter the date of your last flu vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a pneumococcal vaccination? Yes / No . If yes please enter the date of your last pneumococcal vaccine \_\_\_\_\_\_\_\_\_\_­­­­­­­­­

**Contacting you**

I am happy for the practice to contact me from time to time via **text** with practice news, health advice and/or appointment reminders. Yes / No

I am happy for the practice to contact me from time to time via **email** with practice news, health advice and/or appointment reminders. Yes / No

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

|  |  |
| --- | --- |
| **For Office use only :** | **Proof of Identity and Address Provided**  Birth Certificate Driving Licence Passport Utility Bill Allowance Book  Solicitors Letter Offer of Tenancy Other  Specify I.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify Proof of address……………………………  **Verified by (please initial)……………………………………………………………………………………** |

**MOORE STREET SURGERY – ONLINE ACCESS**

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**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, 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.

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Name:

Address:

ID number:

In accordance with The Accessible Information Standard (SCCI 1605 (Accessible Information)) please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual):

To help me communicate I use (e.g. a talking mat, hearing aids):

I need information in (e.g. braille, easy read):

If you need to contact me the best way is (e.g. email, telephone):

**The Accessible Information Standard (SCCI 1605 (Accessible Information))**

Providers of health and adult social care services have new duties to support those who access their services who have sensory impairments and/or learning disabilities. They must:

1. **Identify** the communication and information needs of those who use their service;
2. **Record** the communication and information needs they have identified;
3. Have a consistent **flagging** system so that if a member of staff opens the individual's record it is immediately brought to their attention if the person has a communication or information need;
4. **Share** the identified information and communication needs of the individual when appropriate;
5. **Meet** the communication and information needs identified.

For more information visit: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

**moore Street surgery**

**77 Moore Street,   
Bootle,**

**Liverpool. L20 4SE.**

**Tel: 0151 944 1066**

**Fax: 0151 933 4715   
  
www.moorestreetsurgery.nhs.uk**

**PATIENTS’ CHARTER**

**Partners:**

**Dr Helen Mercer**MBChB (Liverpool 2002), BSc Hons Pharmacology 2001, MRCGP, DRCOG, DFSRH (Female)

**Dr Jackie Anten**  
MBChB, MRCGP, DRCOG, DCH, DFFP (female)

**ALL MEMBERS OF THE SURGERY PRIMARY CARE TEAM ARE DEDICATED TO A QUALITY POLICY TO ACHIEVE HEALTH SERVICES WHICH MEETS THE PATIENT’S REQUIREMENTS**

**Practice Leaflet:**

All new patients will receive a copy of our practice leaflet and copies will be available in reception. A copy will also be available on the practice notice board.

**Surgery Premises:**

Our surgery building will be welcoming, clean and easy for patients to find their way round and will be appropriate for the needs of all users.

**Patients’ rights to General Medical Services:**

Patients have the rights to:

* Be registered with a General Practitioner.
* Change doctor if desired.
* Be offered a health check on joining the practice.
* Receive emergency care at any time from the practice.
* Receive appropriate medications.
* Be referred for specialist or second opinion if they and the GP agrees.
* Have the right to view their medical records, subject to the Acts and to know that those working for the NHS are under legal obligation to keep the contents confidential.

**Changes to procedures:**

When changes are introduced to practice procedures that affect patients, we will ensure that these are clearly explained using leaflets, practice notice board or individual letters, giving as much notice as practicable.

**Home Visits:**

Home visits are reserved for patients who are truly house bound or so incapacitated that they cannot be brought to the surgery. Home visits are based on medical need. Please phone for a home visit before 10am. In almost all cases children can be safely bought to the surgery where we have the best conditions for examination.

We are unable to guarantee a specific GP will visit you as this depends on availability and other factors. The decision to home visit will be at the GPs’ discretion.

**Out of Hours Emergencies:**

We will do everything possible to ensure that our system for contacting the on-call GP is easy to follow, reliable and effective.

**Repeat Prescriptions:**Repeat Prescriptions. Please give 48 hours/2 working days’ notice of repeat prescriptions in writing either using the re-order form provided with your last prescription or by letter or by using the forms available at reception. We DO NOT accept prescription requests via the telephone as this method is prone to error and misinterpretation and is therefore dangerous. We also do requests on line see reception for details.

**Referrals:**

* Urgent referrals to other health and social care agencies will be made within one working day of the patient consultation. Where requested, our GPs will refer you to a private health provider.
* We will normally process non-urgent referrals within five working days of the patient’s consultation or the GPs decision to refer.

**Test Results:**

When a GP or Nurse arranges for a test to be taken, the patient will be Informed how to obtain the result. Results are normally available 2-3 days after the test was taken. You can obtain your results by contacting the Surgery after 9am each working day.

**Privacy & Confidentiality:**

We will respect our patients’ privacy, dignity and confidentiality at all times.

**Appointments:**

***With a GP:*** For routine consultations we will endeavour to offer patients and appointment within **two** working days of the request. For medically urgent requests, we will offer an appointment on the same day.

***With a Nurse:*** For routine appointments we will offer an appointment within five working days.

**Waiting times:**

* Surgeries will normally start on time.
* We expect you to be seen within twenty minutes of the appointment time and in the event of a delay we will offer an explanation.
* When a GP is called away on an emergency we will inform you and give you an opportunity to book an alternative appointment, or if preferred, an alternative GP.

**WITH THESE RIGHTS COME RESPONSIBILITIES AND FOR OUR PATIENTS THIS MEANS:**

* Courtesy to the staff at all times—remember they work under the instruction of the GPs.
* Responding in a positive way to questions asked by the reception team
* To attend appointments on time or give the practice adequate notice if you need to cancel.
* An appointment is for **one** person only. Where another member of the family needs to be seen or discussed another appointment must be made.
* You should make every effort when consulting the surgery to make the best of nursing and medical time—home visits should be medically justifiable and not requested for social convenience.
* When you are asked to give 48 hours’ notice for your repeat prescription, please give us this time as it is to allow for accurate prescribing.

Out of hours calls (evenings, nights and weekends) should only be requested if they are felt to be truly necessary.