**South Hermitage Surgery**

New Patient

Information Form

Please help us get all the details we need to ensure we give you the best possible care and that you make the most of all the services we have to offer by filling out this form when you join us.   
**Please refer to our Welcome Booklet for further details about each section.**

**Are you in the Practice Area? Please ensure you check this before applying to register.**

□ Yes - my postcode is within the Practice area (our Receptionist can check this for you)

□ No - Unfortunately we are unable to accept any patients who do not live within this practice area.

**Administrative** Patient full name:

**Date of Birth:** / / Up to date **mobile number**:

**Current email address:**

We like to remind patients of their appointments the day beforehand as it helps to reduce the number of missed appointments. We can send other messages, such as reminders eg about annual health checks or flu vaccines **& messages about test results or hospital letters.** In addition, we also update patients about changes to the practice in the form of a link to our quarterly newsletter. We also seek feedback from patients about the quality of our service.

We strongly recommend patients to allow us to send text messages as it provides much better access to receiving valuable information.

□ **Yes I wish to receive text appointment reminders and other text messages from the surgery.**

□ **Yes I wish to receive email messages from the surgery about my clinical care.**

**Your named GP**

All patients are now entitled to have a named GP to co-ordinate their care. This person is responsible for overseeing your care, but may not always be the clinician you see.

**We are currently registering all new patients with Dr Sue Murphy as their named GP.**

If you would prefer to choose an alternative, please indicate below:

□ Dr Sue Murphy □ Dr Yvette Smith

□ Dr Laurie Davis □ Dr Annica Goddard

(You can change your mind anytime by advising our staff at the surgery)

**Your Lifestyle**Are you a current smoker? □ Yes\* □ No \*If yes, quantity smoked per day

**Are you interested in receiving Help 2 Quit advice?** □ Yes □ No

Have you ever smoked? □ Yes\* □ No \*The approximate year that you quit? \_\_\_\_\_\_\_\_\_\_\_\_

**Please use our automated machines to let us know your current**:

Blood Pressure:

Weight:

Height:

**Health Check**

We would love all our new patients to have a Health Check when they join us.   
Please ask our receptionist to organise an appointment when you register.

Please tick the relevant boxes so that we can book the right appointment for you.

I am aged between 40 & 74 □ Yes □ No

I have one of the following medical conditions – hypertension, heart disease, stroke, kidney disease, diabetes

□ Yes □ No

For female patients it helps with continuity of care if you tell us whether you are pregnant:  
Pregnant? □ Yes □ No

**Military Veterans**

Are you a military veteran\*? □ Yes □ No

Please make us aware so that we can code your records. We may be able to offer specialist advice and support around veteran related health conditions.

***\*a veteran is anyone who has served for at least one day in the Armed Forces, whether regular or   
 reserve, ie “ex service personnel”***

**Are you a Carer? (Not as part of your employment)**

□ Yes, I am a carer and I would like my name to go onto my GP’s Carers register.

I care for (name/s)

The person/people I care for is/are my:

□ Parent/Parent-in-law □ Husband/Wife/Partner □ Child

□ Other family member

Is the person you care for registered at South Hermitage Surgery?

□ Yes □ No

□ Neighbour/friend

**Online**  □ Yes please, I’d like to receive quarterly newsletters and occasional online surveys about the care and services at the surgery via my email address provided overleaf.

See back pages to register for online access to book + cancel appointments, order repeat prescriptions and, if required, view sections of your medical record\*.

**\*Proof of identity will be required to do this (one form of photo ID + one address verification) unless you already have the NHS App where ID will have already been verified.**

**Data Sharing**

**a) With health professionals**

All patients have an Electronic Summary Care Record (SCR) to assist healthcare staff in their care in case of an emergency. This includes basic information about medicines and allergies.

You can choose to have additional information included in your Summary Care Record (Enhanced SCR), such as illnesses and health problems, operations and vaccinations, treatment preferences and what support you might need. This can enhance the care you receive and help the staff involved in your care make better and safer decisions about how best to treat you. **Please refer to our Welcome Booklet for more information.**□ Please tick this box to **consent** to having this **additional information** included in your Summary   
 Care Record to have an Enhanced Summary Care Record.

Alternatively:

□ If you would like to **opt out** and not have a Summary Care Record at all, please tick this box.  
 Ticking this box is confirmation of your understanding that if you do not have a Summary Care  
 Record other healthcare staff involved in your care (A&E, Shropdoc etc.) may not be aware of  
 your current medications, allergies and any bad reactions to medicines you have had in order to  
 treat you safely in an emergency.

**b) With other persons chosen by you eg relatives/friends**Sometimes patients would like a close relative/friend to contact the surgery on their behalf, however, we are unable to discuss anything about a patient unless we have their express consent to do so.

If you wish to indicate your consent for our staff to be able to do this then please complete the details below. (This can be withdrawn or changed at any time).

Name:

Relationship to me: Tel no:

Indicate what access you consent to being given:

□ all aspects of my records/history □ making/cancelling appointments

□ test results (bloods, x-rays etc) □ ordering/collecting medication  
□ other, please specify

**Electronic Prescriptions**

We are able to send your prescriptions electronically to a pharmacy of your choice. This means you will not need to come to the surgery to pick up the prescription and can instead just collect your medication directly from the pharmacy**. NHS England now requires all patients receiving repeat medication to use a nominated pharmacy.**

□ I do not use repeat medication □ I nominate this pharmacy to send all prescriptions to:

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note you can change this nominated pharmacy at any time.

**Ethnicity** We are collecting this information to help with diagnosis and assessment of your needs. Please tick relevant box or tick decline if you do not wish to provide this information.

**White**: □ British □ Irish □Other White **Black/Black British**: □Caribbean □African

/ □Other Black

**Asian:** □Indian □ Pakistani □ Bangladeshi □ Other Asian

**Mixed**: □White& Black Caribbean □ White& Black African □ White & Asian □ Other Mixed

**Other Ethnic Categories:** □Chinese □Other ethnic groups □**Decline to provide information**

**Accessible Information (Accessible Information Standard -AIS)**

We aim to ensure that people who have a disability, impairment or sensory loss receive information they can access and understand eg in large print, braille or via email. We wish to provide professional communication support if people need it eg from a British Sign Language Interpreter.

□ Yes, I have information or communication needs.

**Please indicate what your information or communication needs are**:

□ Visual impairment □ Hearing impairment □ Language

□ Other (please specify)

**How can we meet these needs?** □ Large Print on correspondence □ Braille □ Translator

□ Other (please specify)

**Your signature** Please sign and date this form:

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**You’ve finished - Thankyou!**

Please hand your completed form to our receptionist.

***Staff use only: check all sections are completed***. ~ Practice boundary

~ Confirm named GP with patient + code records ~ Veteran info to Care Coordinator

~ Book health check appointment (half hour)

~ Check if EMIS ACCESS is required (back page) – verifying ID as required \*\* Guidance sheet to be kept by patient

V 1.21 amended 31/1/23