

## NEW PATIENTS WISHING TO REGISTER WITH OAKHILL MEDICAL PRACTICE

### **IMPORTANT:**

1. New patients are welcome to register with the surgery providing you live within the Practice boundaries, please check our practice booklet or website for details.
2. You will be asked to complete a New Patient Registration form for each person wishing to join the Practice, please ensure you include your NHS number, (if you are unsure of this please ask at your previous GP surgery). Please also include your previous Doctors telephone number.
3. Please bring along with your registration forms 2 separate types of personal identification, one of which needs to be photographic and 1 **proof of current address**. (If you do not have photographic ID then 3 forms of identification are required, please see below for ID requirements)
4. We also need to know your medical history and any medication you are taking as soon as possible so that we can treat you should you need to see a Doctor in an emergency.
5. If you require any medication and are registered with a local GP you will need to go back to your old GP for medication until you have attended for your New Patient Medical.
6. Proof of any medication you are taking **must** be provided with your registration documents in the form of your repeat slip.
7. If you need to see a Doctor urgently before completion of your registration, please follow the instructions in our Practice Booklet.

### **SUITABLE FORMS OF IDENTIFICATION:**

Current passport (Passports of Non-EU nationals should contain either UK Stamps, a visa or a UK Residence permit showing the immigration status of the holder in the UK)

Current Full Driving Licence

Utility Bill or a certificate from a supplier of utilities confirming the arrangements to pay for the service on prepayment terms

Current Local Authority Tax Bill

Bank, Building Society or Credit Union statement or passbook containing current address

Most recent mortgage statement from a recognised lender

Rent Book or Benefits Book or a letter from your landlord confirming your home status

### **ACCEPTANCE CRITERIA**

Patients who comply with the above will not be unreasonably refused registration, and unreasonable includes refusal based on :

Medical condition; Race; Gender or sexual orientation; Disability; Age;

Religious group or religious beliefs; Political beliefs; Appearance or lifestyle.

### **The Practice will however refuse registration if :**

The patient cannot provide ID confirmation; The patient resides outside of the practice area.

The patient has been previously registered with the Practice and been removed from the list.

The patient has a known history of violence.

The patient has demonstrated unacceptable/abusive behaviour prior to registration.

If a patient is refused registration they can request that the reason for this be supplied to them in writing, the Practice will provide this on request.

### **HELP US TO HELP YOU**

1. If you are unable to attend your appointment please let us know as soon as possible to arrange a mutually convenient time.

2. If you arrive more than 10 minutes late for any appointment, you may be asked to make another appointment.

## ACCESS TO MEDICAL SERVICES

### **1. Appointments on the day**

This is for patients who want to see a doctor fairly quickly. Please ring at 8am or soon after, and keep trying if you don't get through immediately. Same day appointments are usually filled quite rapidly, but even if we are fully booked, we always try to ensure that people needing urgent care get seen. Tell the receptionists if you really need to be seen that day, and they will pass the message to the doctor on duty that can prioritise appointments.

### **2. Pre-Bookable Appointments**

If you do not need to be seen that day, it is possible to pre-book an appointment, for up to a month in advance. Where possible you can choose to see a particular Doctor or Nurse, but this may restrict your choice of appointment day or time, especially as not all staff work full-time in the practice.

### **3. Telephone Appointments**

If you just want advice, information about test results, or to discuss something with a doctor without visiting the surgery, you can book a telephone appointment. Please let us have a contact number (preferably a land line number rather than a mobile) in case we need to ring you back.

### **4. Home Visits**

These are for people who are genuinely house-bound.

We can see several patients in surgery in the time it takes to do one home visit, so please do not ask for a visit inappropriately.

Requests for home visits should be made before 10am wherever possible.

### **5. Surgery Opening Hours**

Monday – Friday 8 am to 6:30 pm

We also offer appointments on Fridays 07:00 - 08:00 and Tuesdays 18:30 - 20:00. These appointments are for patients who work and may find it difficult to attend the surgery during normal times.

For appointments and all other enquiries please ring: **01246 296900**

For ordering of repeat prescriptions please ring the above number and press option 1

To check if results are back please ring the above number after 2pm

For further information on our services please go to our website: [www.oakhillmedicalpractice.co.uk](http://www.oakhillmedicalpractice.co.uk)

## When We Are Closed

If you need urgent medical attention when the surgery is closed you should dial 111.

This will connect you to the NHS 111 service free of charge which is provided by a local organisation called Derbyshire Health United.

You will be assessed and directed to the most appropriate point of care for your particular needs.

**OAKHILL MEDICAL PRACTICE**  
 OAKHILL ROAD, DRONFIELD, DERBYSHIRE, S 18 2EJ  
**NEW PATIENT REGISTRATION FORM**

Today's date:	NHS No:	Amended:22.02.17/v2
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PLEASE ENSURE **ALL** FORMS ARE COMPLETED PROPERLY, SIGNED AND DATED OR THE REGISTRATION **WILL** BE REJECTED

**PATIENT INFORMATION**

<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms	Surname	Forename	Middle	Marital Status: Single / Married / Divorced / Widowed / Civil / Separated
Previous Surname		Date of Birth		<input type="radio"/> Male  <input type="radio"/> Female
Address inc postcode		Your Telephone Number/s  Home:  Mobile:  Work:  Do you consent to receiving appointment reminders via SMS Y / N		Next of Kin: (name, address & postcode)      Tel No:  Relationship
Town / Country of Birth		Nationality		
Religion		Occupation		
Previous address, <u>inc postcode</u>		Previous GP details inc contact number		
If you are from abroad, please give your first UK address where you registered as with a GP		Date you first came to the UK	If you were previously resident in the UK, date of leaving:	
If you are returning from the armed forces: address before enlisting		Service No:	Enlistment date:	

**MEDICAL HISTORY**

Please fill in as much information as possible

Current Health: Please list any on-going problems such as: Asthma/Diabetes/Hypertension etc	Any known Allergies:	Current Medication: (proof needed)
Any operations in the past: (date if known)	Any significant illnesses in the past: (date if known)	

## NEW PATIENT HEALTH QUESTIONNAIRE

### WE CANNOT COMPLETE YOUR REGISTRATION WITHOUT THE FOLLOWING INFORMATION

**SMOKING:**

Do you smoke? YES / NO If yes, how many per day \_\_\_\_\_

If yes, please circle    cigarettes    tobacco    cigars    pipe

If current non-smoker, have you ever smoked? **YES / NO**    If yes, when did you stop? \_\_\_\_\_

If you are a smoker and want to stop, would you like information about local smoking cessation services? Yes / No

<b>ETHNIC ORIGIN :</b> (select one)	White (UK)	White (Irish)	White (other)
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi	Other Asian background
Caribbean	African	Asian	Other black background
Chinese	Other mixed background; please state	Other	Ethnic category not stated

**Preferred Communication / Contact Methods:**

Do you require any specific communication requirements owing to a disability, impairment or sensory loss, eg sight or hearing impairment etc?

**Yes**      **No**  

Details: .....

Do you require specific contact or information by any of the following methods?

Text / telephone / SMS / letter / e-mail

other: .....

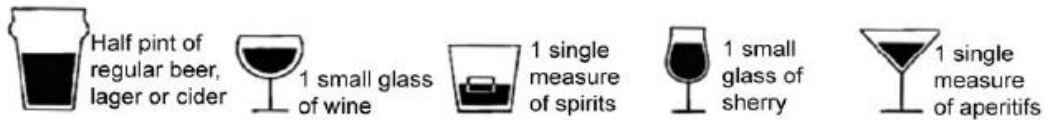
Do you require information in a specific format?   **Yes**      **No**  

Email / verbally / large print / easy read / British sign language etc

Other: please state: .....

# ALCOHOL QUESTIONNAIRE

## This is one unit of alcohol...



## ...and each of these is more than one unit

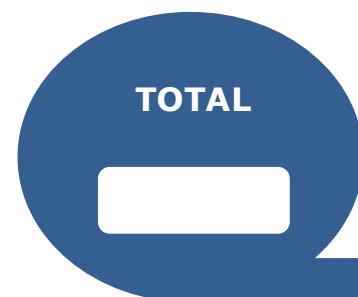


## AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

### Scoring:

A total of 5+ indicates increasing or higher risk drinking.  
An overall total score of 5 or above is AUDIT-C positive.



## Score from AUDIT- C (other side)

**SCORE**

## Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals  
AUDIT C Score (above) +  
Score of remaining questions

**TOTAL**

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# INFORMATION SHARING:

## SUMMARY CARE RECORDS:

The NHS are changing the way your health information is stored and managed.

The NHS Summary Care Record is an electronic record of important information about your health. It will be available to healthcare staff providing your NHS care.

Eg. Hospital, A&E , or if you attend another surgery as a temporary patient etc

Are you happy to have a Summary Care Record? **YES / NO**

1. Express consent for medication, allergies and adverse reactions only
2. Express consent for medication, allergies, adverse reactions and additional information
3. Express dissent – the patient does not want a summary care record

## Sharing Consent

**Sharing Out** Do you consent to the sharing of data recorded here with any other organisations that may care for you?

eg. District Nurses / Physiotherapy / occupational therapy etc

Yes – Share data with other organisations;

No – Do not share data with other organisations

**Sharing in** Do you consent to the viewing of data by 'Oakhill Medical Practice' that is recorded at other care services that may care for you, where you have agreed to make the data shareable?

Consent given

Consent refused

## PATIENT PARTICIPATION GROUP:

The Practice is committed to improving the services we provide to our patients.

To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.

By expressing your interest, it means we can keep you informed of opportunities to give your views and keep you up-to-date with developments within the practice.

If you are interested in being a member of our virtual Patient Participation Group please provide your email address below:

Email: \_\_\_\_\_

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## NHS ORGAN & BLOOD DONOR REGISTRATION

Please leave blank if you do not wish to join the organ or blood donor register or if you are already on the register

### Organ Donation:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick all that apply.

Any of my organs and tissue or

Kidneys                       Liver                       Heart                       Corneas

Lungs                       Pancreas                       any part of my body

Please sign and date confirming your agreement to organ / tissue donation

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**For more information please visit: [www.uktransplant.org.uk](http://www.uktransplant.org.uk) or call 0300 123 2323**

### Blood Donation:

- I would like to join the NHS Blood Donor Register as someone who may be contact and is prepared to donate blood.
- I have given blood in the last 3-years

Please sign confirming consent to be included on the NHS Blood Donor Register

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient / Guardian signature:** .....

**For office use only:** Identity verified by: .....

Documents provided: please tick all that apply: Passport  UK Driving Licence  Birth Cert.

Bank Statement  Marriage cert.  Utility bill  .....

other  .....

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