

## **Western Avenue Medical Centre Registration Process**

Please carefully read all of the documents contained within this registration pack.

Before handing back your registration application, please ensure that you have provided or completed and signed the following documents:

<b>Document</b>	<b>Page number</b>	<b>Completed (please tick)</b>
Photographic ID (driving licence or passport)	n/a	
Address ID (birth certificate, marriage certificate, medical card, local authority rent card, utility bill, bank/building society statement, letter from benefits agency, papers from Home Office, P45)	n/a	
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**Thank you for taking time to complete the registrations forms in full.**

# *Western Avenue Medical Centre*

## **Welcome letter**

Dear New Patient,

Thank you for your registration request with Western Avenue Medical Centre.

Please contact the surgery within the next 7 days to make an appointment with the Practice Nurse for a new patient health check. If you fail to make this appointment or fail to attend, your registration at Western Avenue Medical Centre will not be completed and your medical records will be sent back to the health authority. This will result in you not being able to receive medical care for anything other than acute medical conditions and you will not be issued with repeat prescriptions.

If you are on any repeat medication, please ensure you have at least a months' supply from your previous GP surgery to allow adequate provision during this period.

Please sign and date below to acknowledge that you have read and understood this letter.

I have read and acknowledged this letter and understand the registration process.

Dr Raj Avula & Dr Mark Adams - Partners.

Signed \_\_\_\_\_

Print \_\_\_\_\_

Date \_\_\_\_\_

## Patient Contract

Dear Patient

As you have applied to join our practice we would like to inform you of our practice policies. We advise you to read the following closely and document your agreement with this patient contract with your signature (a copy of which will be kept on your record). Should you refuse to agree to our surgery policies we will not be able to register you as a patient at this practice.

### Violence & aggression

We operate a zero tolerance policy towards violence and aggression. Any patient who behaves in a manner that could be classed as violent or aggressive towards a member of our staff or another patient, on or off surgery premises, will be instantly removed from our patient list and may be reported to the police.

### Repeat Prescriptions

Repeat prescriptions can be ordered by completing the repeat medication slip attached to your prescription and either hand or post into the surgery. Repeat prescriptions can also be ordered online using the Patient Access service. Further details on how to register for this service are contained within your patient registration pack. Your prescription will be ready for collection 48 hours from receipt by the surgery (as outlined in our Practice Leaflet). It is your responsibility to ensure that you order sufficient medication for your needs, particularly during holiday periods.

### Medication not prescribed

The practice has a strict prescribing policy, and there are a number of items which the practice does not prescribe which you should be aware of before registering.

Items not prescribed:

- Hayfever medication (only in exceptional circumstances)
- Sunscreen (only in exception circumstances)
- Zopiclone
- Diazepam
- Temazepam

### Appointments

Appointments can be booked by telephone, in person or online (Patient Access Service). As we are a very busy surgery we are not always able to offer routine appointments at short notice. Should you suffer a genuine medical emergency we may be able to offer an emergency appointment **however, these appointments are reserved for genuine medical emergencies requiring immediate medical attention and cannot be used for reasons of convenience.**

### Home visits

We are only able to offer home visits in **exceptional** circumstances, such as when a patient is genuinely housebound, or where a medical problem makes it impossible for a patient to be brought to the surgery. Lack of transport to attend at the surgery is not an appropriate reason for a home visit.

### Fail to attend

The practice operates a strict policy for patients who fail to attend their appointments. Patients who persistently fail to attend may be removed from the practice list. If you would like to receive text reminders of your appointments please ensure that we have an up to date mobile number saved on your record.

Signed:

Date:

### New Patient Registration Form

Welcome to Western Avenue Medical Centre. Please help us by filling in this questionnaire, as it may take some time for your previous medical records to reach us. The information you give us will be used to provide you with good medical care.

<b>Full name</b>					
<b>Date of birth</b>		<b>Marital status</b>			
<b>Address</b>					
<b>Post code</b>		<b>Telephone number</b>	Home:	Mobile:	
<b>Do you agree to us using these details to contact you?</b>			YES/NO		
<b>Occupation</b>			<b>Next of kin</b>		
<b>Are you a carer OR do you have a carer?</b>				YES/NO	
<b>Do you or your carer have a communication need?</b>				YES/NO	
<b>If 'YES', please specify how that need can be met</b>					
<b>Are you or your family under the safeguarding team?</b>				YES/NO	

### Past Medical History

Please indicate if you suffer from or have suffered from, or there is family history of any of the following:

	You	Family		You	Family
<b>Tuberculosis</b>			<b>Jaundice</b>		
<b>Heart problems</b>			<b>Diabetes</b>		
<b>High blood pressure</b>			<b>Asthma</b>		
<b>Glaucoma</b>			<b>Cancer</b>		
		Please list any current health problems:			

### Drugs and treatment

If you are taking any drugs or undergoing any treatment, please enter below: (please ensure that you have at least 28 days supply of all of your current medication from your previous Doctor)

<b>Name of medicine(s) and doses</b>	
<b>How often do you take it?</b>	
<b>Are there any medicines that upset you? (please list)</b>	
<b>Do you have any allergies? (please list)</b>	

### Vaccination and immunisations

<b>ADULTS: Have you had a course of 5 tetanus injections or had a booster in the last 10 years?</b>	YES/NO
<b>CHILDREN: Please give date of immunisations against:</b>	
<b>Diphtheria</b>	<b>Tetanus</b>

Polio		HIB	
Whooping cough		MMR	
Men C		Rubella (German measles)	

**Lifestyle**

Height			Weight		
Do you smoke?		YES/NO	If 'Yes', cigarettes or pipe tobacco		Cigarettes/pipe tobacco
How many do you smoke a day?			If 'No', have you ever smoked?		YES/NO
If 'Yes', how many a day?			When did you stop?		
In an average week, how many glasses do you drink of the following?					
Pints of beer		If NONE, are you completely teetotal?			YES/NO
Wine					
Spirits					
Do you take regular sport and exercise?					YES/NO
Please circle one of the following		INACTIVE GENTLE MODERATE VIGOROUS			
Do you keeps to any diet? (please circle one)			GOOD MODERATE POOR		
Diet type? (please circle one)			VEGETARIAN VEGAN BALANCED DIABETIC HIGH FIBRE		

**Women only**

We provide a full range of contraceptive services.

Do you use contraception?	YES/NO	If YES, what form?	
When was your last cervical smear taken?			
What was the result?		NORMAL/ABNORMAL	
Have you had a hysterectomy?		YES/NO	

**When you have answered all the questions, please hand this form in to Reception**

**ELECTRONIC PRESCRIPTION SERVICE (EPS)**

The Electronic Prescription Service (EPS) allows the GP Practice to send your prescription to the pharmacy of your choice electronically. This removes the need for you to attend at the practice once your prescription has been authorised by a GP.

Please indicate below which pharmacy you would like your prescriptions sending to:

PHARMACY NAME	
ADDRESS	
PATIENT'S NAME	
SIGNED	
DATE	

**Ethnic Group and Language Questionnaire**

Please tick the appropriate ethnicity box and complete the first language box

Ethnic group	Tick Here
<b>A: White</b>	
<ul style="list-style-type: none"> <li>● British</li> </ul>	
<ul style="list-style-type: none"> <li>● Irish</li> </ul>	
<ul style="list-style-type: none"> <li>● Any other White background (please write below)</li> </ul>	
<b>B: Mixed</b>	
<ul style="list-style-type: none"> <li>● White and Black Caribbean</li> </ul>	
<ul style="list-style-type: none"> <li>● White and Black African</li> </ul>	
<ul style="list-style-type: none"> <li>● White and Asian</li> </ul>	
<ul style="list-style-type: none"> <li>● Any other White background (please write below)</li> </ul>	
<b>C: Asian or Asian British</b>	
<ul style="list-style-type: none"> <li>● Indian</li> </ul>	
<ul style="list-style-type: none"> <li>● Pakistani</li> </ul>	
<ul style="list-style-type: none"> <li>● Bangladeshi</li> </ul>	
<ul style="list-style-type: none"> <li>● Any other Asian background (please write below)</li> </ul>	
<b>D: Black or Black British</b>	
<ul style="list-style-type: none"> <li>● Caribbean</li> </ul>	
<ul style="list-style-type: none"> <li>● African</li> </ul>	
<ul style="list-style-type: none"> <li>● Any other Black background (please write below)</li> </ul>	
<b>E: Chinese or other ethnic group</b>	
<ul style="list-style-type: none"> <li>● Chinese</li> </ul>	
<ul style="list-style-type: none"> <li>● Any other Black background (please write below)</li> </ul>	
<b>Not stated / declined</b>	
<ul style="list-style-type: none"> <li>● Declined: Patient chooses not to supply this information</li> </ul>	

Please advise of your main spoken language	
Translator required	Yes/No



Your emergency care summary



Dear Patient

## 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.

You are free to change your decision at any time by informing your GP practice.





Your emergency care summary



## 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 fillout their details above; you sign the form above and provide your details below:

**Name:** .....

**Please circle one:**

Parent      Legal Guardian      Lasting power of attorney for health and welfare

**For more information, please visit <https://www.digital.nhs.uk/summary-carerecords/patients>, call NHS Digital on 0300 303 5678 or speak to your GP Practice.**

# Overview of the Cheshire Care Record

## Sharing your health and social care information



### **A collaboration between all GP, hospital, community, mental health and social care services provided across Cheshire.**

Whether you are visiting your GP, attending hospital, or being seen in your own home or health centre by a community nurse or social worker, we want you to get the best care.

We can only do this if all the health and social care professionals involved in your care have access to the information they need to make informed decisions with you. By sharing a summary of the information included in your health and social care records, they can provide better care.

### **What is my health and social care information?**

Your shared health and social care information will include information like test results, medications, allergies and social or mental health information relevant to your care.

The professionals treating you will be able to look at computer records of the care you are receiving from other organisations, including your GP or the hospital.

This means:

- You don't have to keep repeating your medical or social care history
- Care professionals have access to the right information when they need it
- There will be less duplicate appointments and tests
- You will receive the right treatment and care more quickly.

Timely access to your health and social care records will ensure that GPs, hospital doctors, nurses, social workers and other health and social care professionals have an overview of your care in order to make the best decisions about your diagnosis, treatment and care plan.

### **Who will be able to see my shared health and social care information?**

Your information will only be accessed by health and social care professionals – such as the district nurse involved in your care – if you have given your consent. You will be asked for this consent the first time that a health or social care professional wishes to view your record. If you have already told your GP that you don't want your health data to be shared, you may wish to reconsider and ask your GP to share your data locally so that a Cheshire Care Record can be created for you. This could be really helpful when making decisions about the care you need. Alternatively you can inform your GP at any time if you don't want your information to be shared.

### **Who are the participating organisations?**

- Cheshire GP Practices
- [NHS West Cheshire Clinical Commissioning Group](#)
- Countess of Chester Hospital NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Cheshire West and Chester Council, Social Care

I have read the information and understand the benefits there are for the local health professionals in being able to view my records at a time of need and the improved care that this would enable me to receive.

Please tick **ONE** of the following:

I **DO** wish to share my record with Local Health Professionals when required

I **DO NOT** wish to share my record with Local Health Professionals

**Your Signature:** .....

**Date:** .....

Please sign and return the slip to surgery. *Thank you.*

*Western Avenue Medical Centre*  
**Patient Consent for Email and Text Message Communication**

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and Western Avenue Medical Centre would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

*Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting the practice.*

Please complete this form and hand it in at the practice reception  
if you consent to any, or all, of the above.

<b>Patient Name</b> _____	<b>Date of Birth</b> ...../...../... .....
<b>Mobile</b> _____	<b>Consent to use?</b> <b>Y</b> <b>N</b>
<b>Email</b> _____ _____ _____	<b>Consent to use?</b> <b>Y</b> <b>N</b>
<b>Signature</b> _____	<b>Date</b> _____