Rothwell & Desborough Healthcare Group

New Patient Health Questionnaire

Thank you for applying to join Rothwell & Desborough Health Care Group. As a new patient to the practice, we would like to ask you to complete the following questionnaire. This will assist in providing you with the best care. You must sign the form on the final page to confirm all the details given are correct. **All information given to us will be confidential and used only in accordance with statutory regulations, e.g. Data Protection Act/GPDR.**

UK residents and those residing in the UK for legal and settled purpose, AND living within the practice area, are entitled to register with us. We reserve the right to remove patients who do not live within our practice boundary. If you register with the practice and are not living in the area this will affect the services that we can provide for you, for example no home visits will be undertaken outside of practice boundaries. All patients found not to be living in the practice area will be removed from our list with 28 days' notice. UK citizens who now live abroad for most of the year may not be entitled to free NHS care.

For online registration purposes please supply a photographic form of ID.

Please read and keep the supplementary information with this form.

If you need any support in completing this form, please ask at the reception. If you have a disability, which means you need information in a different way please contact the surgery and fill in an Accessibility Contact Form.

Please complete all areas that are applicable to you or your child in **CAPITAL LETTERS** and tick the appropriate boxes.

Personal Details

Full name			
Email Address			
Mobile Number		Date of Birth	
Single ☐ Cohabiting ☐ Widowed ☐ Married ☐ Divorced ☐ Separated ☐ Civil Partnership ☐		Occupation	

Main spoken languages?	English ☐	Other (please specify)
Interpreter Required?	Yes ☐	No ☐

Next of Kin			
Name of next of kin		Relationship to you/child	
Next of kin telephone number(s)		Next of kin address (if different from above)	

Medical Details

Please provide information below if known

Height M CM	Weight Kg St. lb
For women aged 25 to 64 Have you had a cervical smear test? Yes ☐ No ☐ If Yes Please state where, when and the result (If known)	**If over 18 please provide recent BP reading.** **This can be taken on one of the practice machines** **BP Reading:** **If BP > 140/90 please arrange 5 day BP reading at reception.**

Are you allergic to any medicine or other substance? Yes ☐ No ☐ If yes, please list below

1.	4.
2.	5.
3.	6.

Family History

Only tick if these apply to first degree relatives. i.e. parents and siblings.	Asthma ☐	Diabetes ☐	Heart disease ☐
	High blood pressure ☐	Stroke/Mini Stroke ☐	Eczema ☐
	Depression ☐	Peptic ulceration ☐	Thyroid disorder ☐
	Glaucoma ☐	COPD ☐	Cancer ☐
	Low Blood Pressure ☐		

Do you drink alcohol? Yes ☐ No ☐ If yes please answer the questions below

1. have you ever felt you should CUT down your drinking? ☐
2. have people ANNOYED you by criticising your drinking? ☐
3. have you ever felt bad or GUILTY about your drinking? ☐
4. have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE- opener)? ☐

If you tick 2 or more boxes above please make a Telephone Consultation with a GP

What are your smoking habits? Ex-Smoker ☐ Date gave up:

Smoker ☐ Never Smoked ☐ E-Cigarettes ☐

How many do you smoke a day? Would you like advice on quitting? Yes ☐ No ☐

If yes please refer to:

https://www.nhs.uk/oneyou/for-your-body/quit-smoking/?gclid=CLyu9cTD_ucCFdWChQodd2QPbQ

Health and Wellbeing Service:

https://www.northamptonshire.gov.uk/councilservices/health/Pages/default.aspx/health-wellbeing/smoking/

Immunisations

If you are from outside the UK please give a copy of your immunisations.

If a child - are they up to date with their immunisations? Yes ☐ No ☐ (if no please specify)

Domestic Abuse: If domestic abuse is affecting your health, you can speak to someone here.
Please tick this box if you would like a GP to contact you. ☐

Online Services

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our on-line service provider (TPP) and access appointments, prescriptions and some sections of your own medical record via the internet.

On-line account

For further information about accessing your online patient information please go to www.rdhg.co.uk/new-patients-2 or ask reception for a leaflet.

I wish to have access to the following online service/s (tick all that apply)

1. Booking appointments	☐	2. Accessing my medical records	☐
3. Requesting repeat prescriptions	☐	4. Detailed Coded Access	☐

Text reminders for appointments

I would like to receive text reminders for appointments? ☐

I consent to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time by contacting the surgery. Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure; however, the practice will not transmit any information, which would enable an individual patient to be identified**.**

For this reason, the practice does not recommend using shared numbers for this service.

I agree to advise the practice if my mobile number changes or if it is no longer in my possession.

Data Sharing

Before making a decision on any of the data sharing options below please visit the website links provided in each section or the New Patient Supplementary Information provided with this form or downloadable from our website.

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. More information is available by visiting SCR - Information for Patients and www.rdhg.co.uk/patient-record

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).

If you are completing this on behalf of someone else other than your child or a child you are responsible for, please ask for a Summary Care Record Patient Consent Form.

Type 1 Opt Out

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research. If you do not want your data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. Visit www.rdhg.co.uk/patient-record for further information and links to the NHS Transparency Notice.

Opt-out

☐ **I do not allow** my identifiable patient data to be shared outside of the GP practice for purposes except my own care. **(XaZ89 / 827241000000103)**

Opt-in (Withdraw Opt-out)

☐ **I do allow** my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care. **(XaZ8A / 827261000000102)**

National Data Opt-out

Due to the introduction of the General Data Protection Regulation (GDPR) in May 2018 there have been national changes with regard to how patients record the sharing of their data. **This was known as a type 2 Opt-out and is no longer registered by the GP.**

If you do not wish your data to be used for research and planning (this may include data that has already been extracted from your GP records because you did not complete a Type 1 opt-out previously) then please visit our website www.rdhg.co.uk/Patient-record for further information or the NHS website www.nhs.uk/your-nhs-data-matters where you can update your preference.

Electronic Prescription Service (EPS)

All prescriptions will now be sent electronically to a nominated pharmacy

Please enter a pharmacy here: _____

(So we can send your prescription direct to them)

Carer Information

e.g support with care after a diagnosis, medical complex needs or elderly care

Do you have a Carer? (*Not normal parent duties*)	Yes ☐ No ☐
If yes, what is their name & contact number?	
Relationship to child if applicable:	
Are you a Carer? (*Not normal parental duties*)	Yes ☐ No ☐
If **Yes**, do you look after someone who is a patient of Rothwell & Desborough Healthcare Group	
If yes, what is their name?	
What is your relationship to them?	
If **No**, please give the address of the surgery or name of the GP who treats the person you care for.	
Please provide a brief description of what kind of support do you feel would help with your/child's needs.	
We will refer you to the Carers Service (Northamptonshire Carers) for further information and support. Please tick if you do NOT wish to be referred ☐ Northamptonshire Carers provides information and advice and free services such as gym sessions, sitting service, holidays and emotional support.	
Are you an Adult with social care involvement? If yes, please state the reason why	Yes ☐ No ☐

If Registering a Child please complete the following:

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child

Who has parental or legal responsibility for the child?		☐ You as the legal parent/guardian/adoptive parent ☐ **Other** (please specify)	
Name:		Contact Number:	
Evidence of parental responsibility (birth certificate/social care information):			
If you are the parent/guardian/foster carer /kinship carer **but cannot** consent please detail below who can			
Name:		Contact Number:	
Relationship to child:			

Looked after children

If a child, are they looked after?	Yes ☐ No ☐	
If Yes, under what arrangements:	☐ Section 20-Voluntary Care ☐ Subject to a Full Care Order ☐ Placed for adoption	☐ Subject to an Interim Care Order ☐ Unaccompanied Child Asylum Seeker

☐ Private arrangement/Private Fostering/informal arrangement (please note you have a duty to notify social care of this arrangement)

What is Private Fostering?

A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

*Private Fostering **includes** a child living with:*	*Private Fostering **does not** include a child living with:*
• godparents • great-grandparents • great aunts or uncles • family friends • step parents where a couple isn't married or in a civil partnership • cousins • a host family which is caring for a child from overseas while they are in education here	• brothers • sisters • grandparents • aunts • uncles • step parents where a couple is married or in a civil partnership • mother • father • children and young people who are being looked-after by the Local Authority

Name of school or Nursery:		Home schooled: ☐
Does the child have a social worker? Yes ☐ No ☐	Name of social Worker:	

Are there any other Agencies involved in their care? Yes ☐ No ☐

Contact Details:

I confirm that:

- **The information I have given in this form is correct**
- **I am the parent or legal guardian of the dependent person I am making a choice for set out above (if applicable)**

Signed **Date (dd/mm/yyyy) / /**

Signed on behalf of patient (if applicable)	**Full Name:**
(Minors under 16 yrs. adults lacking capacity)	**Relationship:**

Thank you for providing this information.

We look forward to providing you with a high standard of care in a friendly and professional manner.

Please take a copy of our practice leaflet.

FOR RECEPTION USE ONLY

For a patient to register with the practice they must be Resident in the UK and living within our Practice Boundary.
For online registration please check photographic form of ID (such as passport or driving license)
Evidence to support application must be relevant to the Patient Only (NOT other family members):

Evidence of Identity – UK resident (Photo ID)	**Identity Verified by (Initials) & Date**
Passport	
Photo Driving Licence / Photo Identity card/ Birth certificate	

Evidence of Status – Patients outside the UK	**Identity Verified by (Initials) & Date**
Visa	
Resident Permit for more than 6 months	
IMPORTANT - Form checked by	