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**Phoenix Royal**

**Agricultural University**

**University Surgery : Stroud Road, Cirencester, GL7 6JS**

**Main Surgery : 9 Chesterton Lane, Cirencester, GL7 1XG**

**Tel: 01285 652056**

**Website:** [**http://www.phoenixhealthgroup.co.uk**](http://www.phoenixhealthgroup.co.uk)

# New Student Patient Registration

#  Welcome Pack

**Thank you for choosing to join our Practice**

Inside this pack you will find the following documents:

# (Please make sure all the boxes within the form are completed in full)

1. Patient Registration Questionnaire
2. Health and Lifestyle Information
3. Sharing Your Information
4. Patient Participation Group
5. Patient Signature
6. Registration Form (GMS1) – Separate Form

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| **Our Doctors:-**At the Royal Agricultural University and Cirencester are:-Dr Rohit Sethi, Dr Ali Nichol, Dr Peter Hill, Dr Khalid Al-Khayat, Dr Naomi Vernon Dr Amy Louise Douglas, Dr Eleanor Curry and Dr Ariadne Strong**Our Surgeries are held at:-**

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| Royal Agricultural University | 9 Chesterton LaneCirencester | Clarks HaySouth Cerney | Church LaneKemble |

**Practice Leaflets are available from each site** |

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| **To registration with our Practice** - Please complete this form in **BLOCK CAPITALS** and make sure you tick the boxes, as appropriate along with a “Family doctor services registration form” (GMS1).If you have been registered with an NHS doctor before please let us have your NHS number. This will help us get your records from your previous surgery. |

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| Full Name : Date of Birth : **Additional Information**:-Maiden name, if different :Previous Name, if applicable :Please list other residents of your home who are already registered with us:Name Date of Birth |

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| **Contact Information**:-E-Mail address : Mobile Telephone number :Home Telephone Number : How would you prefer us to contact you?Letter/Phone/Text/E-Mail |

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| **Next of Kin** :-Name of next of kin :Relationship with next of kin :Contact details for next of kin :Do you consent to sharing your medical records with your next of kin? YES/NO |

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|  | **Looking After A Family Member** |  |  |
| **Are you looking after someone?** Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.  | Yes/No |  |
| **Name of Person you are looking after :****Relationship to you :** |  |  |
| **Is someone looking after you?**Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice. | Yes/No |  |
| Carer’s name:    | Relationship to you:  |  |  |
| Telephone number of carer:  | Is your carer registered with us?    |  |  |
| Address of carer:    |  |  |

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|  | **Your Ethnic Origin (Please tick one)**  |  |
| Black Caribbean/British  | Indian / British Indian  | Arabic  | White (UK)  |
| Black African /British  | Pakistani / British Pakistani  | Chinese  | White (Irish)  |
| Other Black Background  | Bangladeshi / British Bangladeshi  | Other  | White (Other)   |
| Other Mixed Background  | Other Asian Background  |   | Ethnic Category Refused  |
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| **Do you need an Interpreter? Yes/No**  |  |
| **If Yes please state language :** |  |
| **Do you need help with mobility/hearing/speaking? (tick all that apply)**  |  |
| Wheelchair  | Walking aid  | Hearing aid  | British sign language  | Makaton signlanguage  |
|  |  |   |   |  |   |
| Lip reading:  | Large print:  | Braille   | Other. Please state:  |
| **Are you currently?**  | Homeless  | A Refugee  | An Asylum Seeker  |
| **Are you an ‘Assistance Dog’ User?**  |  Yes  |  |  No  |

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| **Your Medical Background**  |
| Are there any serious diseases that affect any family member? If yes please tick all that apply below and state family member:-  |
| DiabetesState Type 1 or 2: Who:  | Asthma Who:  | Thyroid disorder Who:  | Stroke Who:  | COPD Who:  |
| Heart Attack under age of 60 Who:  | Cancer (Specify type)  Who:  | High Blood pressure Who:  | Any other important family Who: illness. Please state:    |
| Do you suffer from any allergies and sensitivity to medicines, food & dressings?If yes please give details :  | Yes/No  |
| Please state any mental disabilities you have:  |   |
| Are you able to administer your own medicines?   | Yes or No | If no please give details, e.g. swallowing or opening containers:  |
| What chronic medical conditions have you had?  | Date of Diagnosis:   |
| What operations have you had?   | Date of operation/s:   |
| What injuries have you had?  | Date of injury/s   |

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| Are you under the care of a hospital specialist at the moment? YES/NOIf Yes please give details:-Name of Specialist :Hospital :Diagnosis : |
| Please list any tablets, medicines or other treatments you are currently taking / undertaking:-   |
| Please give details of vaccinations you have had:- |

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| **Lifestyle**  |  |  |
| Have you ever been a smoker? Are you currently a smoker?  | Yes Yes  |  | NoNo |
| If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?  |  |  |
| Cigarettes:  | Cigars:  |  | Tobacco:  |
| Please confirm your:-Height :Weight : |  |  |

**Alcohol Questionnaire**



Units of

Alcohol

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| Questions | Scoring system | Your Score |
| 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink that contains 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 have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 or more units of alcohol on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you found you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

**Sharing Your Medical Record**

Your patient record will be held securely and confidentially on our electronic system.

If you require treatment in another NHS healthcare setting such as an Emergency Department or Minor Injury Unit, those treating you would be better able to give you appropriate care if some of the information from the GP practice were available to them. This information can now be shared electronically via:-

**SCR - NHS SUMMARY CARE RECORD (used nationally across England). This includes basic information, i.e. medications and allergies.**

**SCR with Additional Information can be added, if you are happy to do so. This includes:-**

* **Significant problems (past and present)**
* **Significant procedures (past and present)**
* **End of Life Care**
* **Immunisations**

**GLOUCESTERSHIRE SHARED HEALTH AND SOCIAL CARE INFORMATION (Joining up your information - JUYI) Used locally to share information with clinicians and Gloucestershire County Council Social Care, where they are involved in your care.**

In all cases, the information will be used **only by authorised healthcare professionals** directly involved in your care. Your permission will be asked before the information is accessed, unless the clinician is unable to ask you and there is a clinical reason for access.

Please note that these records are **NOT CONNECTED** with the Health and Social Care Information Centre care.data project, which has been discontinued.

**Clinical Audit** – Anonymised patient information is compared against national guidelines to ensure that you receive appropriate care and treatment.

Parents, guardians or someone with power of attorney can ask for people in their care to be opted out, but ultimately it is the GP’s decision whether to share information, or not, because of their duty of care.

If you are caring for someone and feel that they are able to understand, then you should make the information about the different methods of sharing available to them.

Please ask a member of the GP practice staff for details of where to find more information about each of the sharing methods.

If you would rather we didn’t share your data we will put an entry on your record which will prevent your information from being shared.

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| **Differences between the Gloucestershire Shared Record and the Summary Care Records** |
|  | **Gloucestershire shared health and social care information (JUYI)** | **Summary Care Record** |
| **Shared** | * Across Gloucestershire
* Across health care settings, including urgent care, community care and outpatient departments
* With GPs, and with NHS clinicians employed by Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Care Services NHS Trust (Community hospitals and community-based services, such as district nursing), 2gether NHS Foundation Trust (mental health services), South Western Ambulance Service NHS Foundation Trust.
* With Gloucestershire County Council social care.
 | * Across England
* Across health care settings, including urgent care, community care and outpatient departments
* With GPs, and with clinicians employed by any NHS Trust or organisation involved in your care across England
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| **Information source** | * GP record
* Other medical records held by different NHS organisations in Gloucestershire
* Gloucestershire County Council social care
 | * GP record
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| **Content** | * Your current medications
* Any allergies you have
* Any bad reactions you have had to medicines
* Your medical history and diagnoses
* Test results and X-ray reports
* Your vaccination history
* General health readings such as blood pressure
* Your appointments, hospital admissions, GP out-of-hours attendances and ambulance calls
* Care / management plans
* Correspondence such as referral letters and discharge summaries.
 | * Your current medications
* Any allergies you have
* Any bad reactions you have had to medicines
 |

**Please tick , as appropriate, in order to register your wishes.**

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| **1. Your Choice for SCR** | **Please tick One Box only** |
| I would like a Summary Care Record with additional information added (See Section on Sharing your Medical Record) |  |
| I would like my information shared through the Summary Care Record (allergies and current medications) |  |
| I do not want my information shared through the Summary Care Record |  |
|  |  |
| **2.Your Choice for Gloucestershire shared health and social care information (JUYI)** | **Please tick One Box only** |
| I would like my information shared through the Gloucestershire shared health and social care information project |  |
| I do not want my information shared through the Gloucestershire shared health and social care information project |  |

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| **Clinical Audit – This anonymised data is used to help identify patients at risk of developing diseases and preventing conditions from becoming more serious.** | **Please tick Box if you don’t want your data shared** |
| I don’t want my anonymised data shared. |  |

If you are happy for your data to be used for health purposes, but would like to opt out of your information being used for research and planning purposes you can find out more and set your opt out choices at <https://www.nhs.uk/your-nhs-data.matters/>.

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| **Patient Participation Group (PPG)**  |
| 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, you will be helping us to plan ways of involving patients that suit you
* It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice
* If you are interested in getting involved in the PPG, please tick yes in the box below.
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| Yes I am interested in becoming involved in the PPG If Yes are you happy for us to give your contact details to a PPG rep?Yes/No | No I am not interested in becoming involved in the PPG  |

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| **Other Information**  |  |
| Do you have a “Living Will”? (A statement explaining what medical treatment you would not want in the future)?  | Yes No  | If “Yes”, can you please bring a written copy of it to your first appointment.  |
| Have you nominated someone to speak on your behalf, should you lack mental capacity (e.g. a person who has Power of Attorney)? For property and financial affairs?Yes No For health and personal welfare?Yes No  | If “Yes”, please state their Name: Address: Phone number:  |

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| **Signature**  |
| Patient signature:   | Signature on behalf of patient:     |
| Date of signature : |  |

Thank you for completing this form. For more information about the services we offer, please refer to our Practice Leaflet, Facebook page or see our website:-

 **http://www.phoenixhealthgroup.co.uk**

 **Please complete AND SIGN the GMS1 Form attached**