HARTSHILL MEDICAL CENTRE

Welcome to Hartshill Medical Centre

To register at our practice we require you to:

- Complete this form
- Complete the purple NHS registration form (GMS1)
- Present a copy of your repeat prescription
- Present photographic ID

About you

Title: _____ Date of Birth: ____ /____ /_____

Last name: _____

First name(s): _____

Preferred Pronouns: he/him she/her they/them other:_____

Home address: Contact Numbers:

_____ Home: _____

_____ Mobile: _____

_____ Work: _____

Post code: _____

Email address: _____

We often utilise text and emails as a mean of communicating with you, would you be happy to receive Texts: Yes □ (XaQid) No □ Emails: Yes □ (XaRFI) No □

Occupation: _____

If you are still in education, which nursery/ school/ college do you attend: _____

Are you a carer? Yes □ No □ If so, who for?_____

Are you current military personnel? Yes □ No □ Are you a veteran? Yes □ No □

Ethnicity:

Asian/Asian British- Bangladeshi	□	Mixed ethnic group- White + Asian	□
Asian/Asian British- Indian	□	Mixed ethnic group- White + Black African	□
Asian/Asian British- Pakistani	□	Mixed ethnic group- White + Black Caribbean	□
Asian/Asian British- Other	□	White British	□
Black/Black British- African	□	White Irish	□
Black/Black British- Caribbean	□	White Other	□
Black/Black British- Other	□	Other _____	

Accessibility

Preferred language:

Arabic □ English □ Gujurati □ Hindi □ Punjabi □ Urdu □ Other: _____

Would you require a translator for appointments? Yes □ No □

Do you have a visual impairment? Yes □ No □

If yes, do you have partial blindness or total blindness

How can we help you to access our service? _____

Do you have hearing loss? Yes □ No □

Is your hearing loss: Mild Moderate Severe Profound

Do you require a BSL translator?

Do you lip read? Yes □ No □

How can we help you to access our services? _____

Do you have a mobility issue that could impact you accessing our services? Yes □ No □

If yes, what issue(s) do you have? _____

How can we help you to access our services? _____

Do you have a service animal? Yes □ No □

Current Medication

Please record your current medication below, including the drug name, the dose and how often you take it. If you have a repeat prescription from your last practice, please attach that.

Do you receive any special medication from the hospital? Yes □ No □

Do you have any allergies? If so, what happens?

Which Pharmacy would you like us to set as your usual Pharmacy? _____

Your personal health

Please indicate if you have ever had any of the conditions listed below and if you have, please give us some information, including when this happened (date) and any other relevant information relating to the condition. Your medical records will be transferred from your last practice in due course, but this will help to give us an immediate overview of your health.

Condition	**Yes**	**Further information**
Alcohol dependence/ addiction		
Asthma		
Blindness/ low vision		
Cancer		
COPD (emphysema/ chronic bronchitis)		
Deafness		
Deep Vein thrombosis (DVT)		
Diabetes		
Drug dependence/ addiction		
Eczema		
Epilepsy		
Glaucoma		
Heart attack		
Hepatitis		
HIV		
Hypertension (high blood pressure)		
Long COVID		
Meningitis		
Psoriasis		
Pulmonary Embolism (PE)/ Clot on the lung		
Stroke		
Testicular problems		
Thyroid Disease		
TIA/ Mini-Stroke		
Tuberculosis (TB)		
Women's health problems breast/ gynaecology		

Are there any other conditions you would like to make us aware of?

Is there any significant illness that are in your family, such as cancer, strokes or heart attacks? If so, please give us details of which family member and at what age.

Health Questionnaire:

What is your current:

Height: _____ Weight: _____

Bloods Pressure: ____/____ *(There is a blood pressure machine in reception)*

Alcohol:

Please circle the answer that is correct for you. Score

- *How often do you have a drink containing alcohol?*

Never (0) Monthly or less (1) 2 - 4 times a month (2) 2 - 3 times per week (3) 4+ times a week (4) _____

- *How many drinks containing alcohol do you have on a typical day when you are drinking?*

1 - 2 (0) 3 - 4 (1) 5 - 6 (2) 7 - 9 (3) 10+ (4) _____

- *How often do you have six or more drinks on one occasion?*

Never (0) Less than Monthly (1) Monthly (2) 2 - 3 times per week (3) 4+ times a week (4) _____

Total Score: _____

Smoking:

Do you smoke? Yes □ No □ If no, have you ever smoked Yes □ No □

If you smoke, how many cigarettes do you smoke per day? _____

If you smoke roll-ups or a pipe how many grams in a week? _____

Are you interested in giving up smoking? Yes □ No □

If yes, would you like some information sending to you regarding help and support? Yes □ No □

Recreational drugs:

Do you use any recreational drugs? Yes □ No □

If yes, what are you currently using? _____

Would you like help to stop using drugs? Yes □ No □

If yes, would you like some information sending to you regarding help and support? Yes □ No □

Health Questionnaire:

Physical Activity:

1 Please tell us the type and amount of physical activity involved in your work

		Please Mark one box only
A	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc)	
B	I spend most of my time at work sitting (such as in an office)	
C	I spend most of my time at work standing or walking. However my work does not require much intense physical effort (eg shop assistant, hairdresser, security guard, childminder etc)	
D	My work involved definite physical effort including handling of heavy objects and use of tools (eg plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc)	
E	My work involved vigorous physical activity including handling of very heavy objects (eg scaffolder, construction worker, refuse collector etc)	

2 During the **last week** how many hours did you spend on each of the following activities?

	Please mark one box only on each row	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc				
B	Cycling, including cycling to work and during leisure time				
C	Walking, including walking to work, shopping, for pleasure etc				
D	Housework/childcare				
E	Gardening/DIY				

3 How would you describe your usual walking pace? Please mark one box only.

Slow pace (ie less than 3mph)	Steady average pace	Brisk pace	Fast pace (ie over 4mph)

Healthy adults should aim at 30 minutes – 5 times a week exercise. As we get older stay active whether it is a hobby such as gardening or playing bowls or joining an exercise class. Please tick when read □

External access to your data

There are three systems in which organisations, other than your Practice, can view your clinical records.

We are legally obliged to supply the data. Patients need to be aware of this so that you can make an informed choice as to whether you are happy to share this data or if you wish to 'opt out'. All patients have the right to opt out of any or all three systems. If you ***do not*** wish to have your information shared then you need to inform the Practice in writing so that we can block the extraction of your data.

- Summary Care Records: these records are held centrally and contain information about patient medication, allergies and adverse reactions to medicines, enabling healthcare staff treating patients out of hours or in an emergency to access key clinical information.
- GP data in A&E: clinicians in A&E and other Urgent Care settings would be able to access certain parts of your GP clinical records, but only after asking for your consent at the time.
- Better Information Means Better Care (CARE.DATA): NHS England has commissioned the care data service that will extract data from the GP Practices every month to be shared in care settings. Their aim is to research improvements in healthcare, services and quality of care across the country. Data to be extracted includes your NHS number, date of birth, post code, gender. Coded information about referrals, NHS prescriptions and other clinical data will also be shared. Your name will not be included. Data will then be anonymised.

The aim is to improve the care of patients, improve clinical safety and quality.

If you are happy to share your data, you do not need to do anything as your data will be automatically extracted.

You can choose to share or not share data in one, two, or all three areas.

If you ***do not wish to share*** your data in any, or all of these three areas, please sign below.

Only sign your name against the areas that you want to opt out of. *(If you change your mind in the future, please contact the Surgery)*

If you are completing this form on behalf of a child please add your details here:

Your name: _____ Signature: _____

Relationship to patient: _____ Date: _____

SUMMARY CARE RECORDS

I have made an informed decision and **DO NOT** want a Summary Care Record:

Signature: _____ Date: _____

GP DATA IN A&E AND OTHER URGENT CARE SETTINGS

I have made an informed decision and **DO NOT** want my data to be shared for the GP data scheme in A&E:

Signature: _____ Date: _____

Better Information Means Better Care (CARE.DATA)

I have made an informed decision and **DO NOT** want my data to be shared for the Care.Data scheme:

Signature: _____ Date: _____

Official use only: Date actioned by GP Practice: _____

External access to your data

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

At some point in the future you may need to be treated by health and care professionals that 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 an SCR means that, when you need healthcare, you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

You can choose to have additional information included in your SCR, which can enhance the care you receive. This information 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
- Who should be contacted for more information about you

What to do next

If you would like this information adding to your SCR, then please sign and date below:

Signature: _____ Date: _____

If you are signing on behalf of a child or vulnerable person please complete the below information:

Name: _____ Relation to patient: _____

If you require any more information, please visit **https://digital.nhs.uk** or phone NHS Digital on **0300 303 5678** or speak to your GP Practice

HARTSHILL MEDICAL CENTRE

Ashwell Road
Hartshill
Stoke-on-Trent
ST4 6AT

0300 123 1893

Help us to help you: Patient contract

Dear Patient,

Thank you for your interest in joining the Practice. We aim to provide a high standard of service to our patients. For us to maximise the service we are able to give, we request patients agree to a number of practical measures.

- Agree to use the 'total triage' system for arranging appointments
- Home visits should only be requested for housebound patients or those genuinely not able to come to the Surgery.
- Repeat prescriptions should be ordered in line with practice policy, giving 2 working days notice.
- Always treat members of staff with courtesy and respect and they will do likewise. Rudeness, swearing, offensive and aggressive behaviour to staff, other patients and visitors in the waiting room will not be tolerated and may result in immediate removal from the list.
- Please cancel any appointment with plenty of notice.
- Patients should do whatever possible to improve their own health.

By signing below you agree to the above patient contract as well as stating that all of the information provided in this registration document is honest and factual.

Signature: _____ Date: _____

If you are signing on behalf of a child or vulnerable person please complete the below information:

Name: _____ Relation to patient: _____