# Welcome to Rosegarth and Siddal Surgeries

**You will be registered with Dr Helen Davies. This does not prevent you from seeing any other clinician in the practice.**

**It is essential that you provide proof of I.D. for each person over the age of 16. Acceptable forms of I.D. are: driving licence, passport, utility bill or bank statement from the last 3 months.**

Once you have registered with the practice your medical records will be requested from the Health Authority. It may take some time before your full record is available to us, so any information you have available will ensure a smooth transition of your care to us, and will be will be appreciated.

**Patient Name:** _____ **DoB:** _____

| | |
|---|---|
| **Are you are a registered carer?**<br><br>**Yes ☐ No ☐** | **If Yes, whom are you caring for? What relation are they to you:……..**<br>**Name:**…….<br>**Address:** ……..<br>**Tel Numbers** …… |
| **Do you have a carer?**<br><br>**Yes ☐ No ☐** | **If Yes, who is your carer ? What relation are they to you:……..**<br>**Name**: ……..<br>**Address**: ……..<br>**Tel Numbers**: …….. |
| **Do you have a Next of Kin?**<br><br>**Yes ☐ No ☐** | **If Yes, who is your Next of Kin and what relation are they to you?** ……..<br>**Name:** ……<br>**Address:** ……..<br>**Tel Numbers:** …… |

**YOUR NEW PATIENT PACK CONTAINS:**

- ***GMS1form*** – **This form is compulsory**.
  More information on blood and organ donor registration is available on www.nhs.uk or 0845 60 60 400.
- ***New Patient Questionnaire* – This form is compulsory**
- ***Your Electronic Health Record*** **-** sharing consent/opt out for *Summary Care Record & Enhanced Sharing.* **This form is compulsory.**
- **Others:** ***'How to Order Your Prescriptions'*** leaflet; "***Online Services"*** Leaflet

  Please visit our websites www.rosegarthsurgery.co.uk or www.siddalsurgery.co.uk for more information.

## Your Electronic Patient Record & Sharing of Information

Today, electronic records are kept in all the places where you receive healthcare. These NHS Care Services can usually only share information from your records by letter, email, fax or phone. At times, this can slow down your treatment and mean information is hard to access. You can avoid this by consenting for your electronic records to be shared:

### 1. SystmOne (enhanced) Sharing

Your GPs computer (SystmOne) system has two settings to allow you to control how your medical information is shared:

**Sharing Out** – This controls whether your full GP electronic patient record can be shared with other NHS Care Services where you are treated who use the same system as ours. Please record your preference:

**Please tick:** Sharing Out **Yes** (shared) □ or **No** (not shared) □

**Sharing In** – This controls whether you agree for this practice to view information you've agreed to share at other NHS Care Services who use the same system as ours. . Please record your preference:

**Please tick:** Sharing In **Yes** (viewable) □ or **No** (not viewable) □

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### 2. Summary Care Record

**The Summary Care Record is used by other NHS organisations such as A&E and Out of Hours. These organisations can only access this information with your permission, but there may be circumstances where staff cannot ask you. For example, if you are unconscious, healthcare staff may look at your record without asking you.**

**Summary Care Record Consent Options (Please tick ONE option only)**

**I consent for medication, allergies and adverse reactions to form a Summary Care Record** □

**OR**

**I wish to Dissent\Opt Out from the Summary Care Record** □

***Section A:***

Full name .....Date of Birth…….....

Signature .....Date……..

***Section B.*** If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name .....Your signature.....

Relationship to patient .....

**(PLEASE RETURN COMPLETED FORMS TO ROSEGARTH SURGERY OR SIDDAL SURGERY)**

| **ROSEGARTH/SIDDAL SURGERY PATIENT HEALTH QUESTIONNAIRE – ADULT** | | |
|---|---|---|
| *Please complete the following health questionnaire in full and hand it in with your registration documents.* | | |
| **Name:** | **D.O.B:** | **Age:** |
| **Address:** | | |
| **Home Phone:** | **Mobile:** | **Email:** |
| **Ethnicity:** | **First Language:** | |

| **Medication: Please list any medicines/tablets you are taking at the moment:** | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| **Past Medical History: Please list your past medical history:** | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| **Allergies: Are you allergic to any medicines, substances or foods? Yes/No** |
|---|
| **If Yes, please give details:** |
| |

| **Family History: Do any members of your family have any of the following conditions?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Condition** | **Yes** | **Age** | **How Related** | **Condition** | **Yes** | **Age** | **How Related** |
| **Diabetes** | | | | **Skin Disease** | | | |
| **High Blood Pressure** | | | | **Nervous Disorders** | | | |
| **Heart Attack** | | | | **Congenital Disorders** | | | |
| **Stroke** | | | | **Cancer** | | | |
| **Epilepsy/Fits** | | | | **Allergies to Medicine/Food** | | | |
| **Asthma** | | | | **Any other Disease** | | | |

We would like to invite you to make an appointment for a new patient health check please make an appointment with our health care assistant.

**To allow us to process your application swiftly please tick one of the following boxes that relates to your medical history**

| | |
|---|---|
| I am aged under 40 with no long term health problems □ | Under 40 with long term health problems □ |
| I am between the age of 40 and 75 years and do not have any long term health problems such as asthma/COPD/Diabetes/Coronary Heart Disease/Epilepsy/Peripheral Vascular Disease/Atrial Fibrillation/Rheumatoid Arthritis/Hypertension/Stroke □ | |
| I am 75 years or older with no problems □ | I am 75 years or older with problems □ |
| I am under the age of 75 years and suffer from a long term health problems e.g. Asthma /COPD /Diabetes Coronary Heart Disease/Epilepsy/Peripheral Vascular Disease/Atrial Fibrillation/Rheumatoid Arthritis/Hypertension/Stroke | |
| | |
| | |

| THIS BOX IS TO BE COMPLETED BY PRACTICE STAFF | |
|---|---|
| NHS Health Check Appointment booked □ | Smoking Cessation Advice Appointment booked □ |
| Annual Review Required (Diabetes etc IT) □ | New Patient Health Check Offered (XaCGg) □ |
| Patient taking 5+ medications task to pharmacist □ | |

**PATIENT AUDIT (for patients aged 16+)**

**Name:** _____ **Date of Birth:** _____

**Can you please answer the following questions:**

**Alcohol: How many units of alcohol do you drink each week?**
***(1 unit = half pint of beer, 1 small glass of wine, or a pub measure of spirits)***

**UNIT GUIDE**

*1 unit is typically*

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

***The following drinks have more than one unit:***

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" Lager, 250ml glass of wine (12%)


**The following questions are validated as screening tools for alcohol use**

| **AUDIT-C QUESTIONS** | **Scoring System** | | | | | |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | **3** | 4 | Score |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ 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 | |
| **If your score is less than 5 please go to the smoking section (if you smoke).** | | | | **Total** | | |
| **AUDIT Questions** (after completing the 3 questions above if your score is 5 or more). | **Scoring System** | | | | | |
| | 0 | 1 | 2 | **3** | 4 | Score |
| 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 | |
| If your score is 7 or more please book an appointment with one of our practice nurses for advice. | | | | | **Total** | |

| **SMOKERS** | | |
|---|---|---|
| **Smoking:** | | |
| **Do you smoke? Yes/No** | **If Yes, how many per day?** | **What age did you start smoking?** |
| **Smokers: Would you like to be referred to our smoking cessation clinic Yes/No** | | |
| **Ex-smokers:** | **What age did you stop?** | **How many did you smoke per day** |

| | |
|---|---|
| **We strongly advise that you stop smoking. We can offer counselling and treatment to help you stop. Please make an appointment or you may be referred to the Stop Smoking Services, would you like us to make you an appointment.** | **Yes / No (Please circle)** |

| **.**<br>**ARE YOU A CARER?** | | |
|---|---|---|
| **Are you a carer? A carer is someone who looks after a relative, friend or neighbour who could not manage without their help.** | **Yes** | **No** |
| **Is the person you care for registered with our practice? Yes / No** | **What relation are they to you: Relative / Friend / Neighbour / Other** | |
| **If the person is register with our practice please provide their name and telephone number in the box opposite.** | | |

## EMERGENCY CONTACT DETAILS

**Notes**
If you feel we should have an emergency contact for you, please complete the following information. You should notify the individual(s) you have named above that you have provided us with this information and we will hold this information within your medical records.

Completion of this section is voluntary.

| **CONTACT IN EMERGENCY** | **RELATIONSHIP to you**<br>(Please indicate if this person is your NEXT OF KIN): |
|---|---|
| **NAME:** | |
| **ADDRESS:** | |
| **TELEPHONE NUMBERS (**home/ work/mobile): | |

| **OTHER CONTACT IN EMERGENCY** | **RELATIONSHIP to you**<br>(Please indicate if this person is your NEXT OF KIN): |
|---|---|
| **NAME:** | |
| **ADDRESS:** | |
| **TELEPHONE NUMBER:** | |

**Thank you for completing this form please hand it to one of our reception staff with your registration documents.**
Updated 16/11/2017

## Consent to access GP online services

### The patient

| | |
|---|---|
| Surname | Date of birth |
| First name | |
| Address<br><br>Postcode | |
| Email address | |
| Telephone number | Mobile number |

**Repeat Prescriptions**

I would like to: Collect in Person ☐ or Pharmacy to collect on my behalf ☐

Which Pharmacy?

### Online Services

| **I wish to have access to the following online services (please tick all that apply):** | |
|---|---|
| 1. Online appointments booking | ☐ |
| 2. Online prescription management | ☐ |
| 3. Detailed medical records | ☐ |
| **I wish to access my medical record online and understand and agree with each statement (tick)** | |
| I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | ☐ |
| I will be responsible for the security of the information that I see or download | ☐ |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement | ☐ |
| If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | ☐ |

**Patient Consent**

I consent to the practice providing me with the online facility to book/cancel appointments and order repeat prescriptions through SystmOnline. It is my responsibility to keep my account secure by keeping my log in details confidential. I understand that I can terminate my account at any time by contacting the surgery, or change my log in details by re-registering, and that this form will be kept on my electronic records. I will use this service responsibly and in the case of any abuse of the service, Rosegarth & Siddal Surgery can prevent me from accessing the service by removing access to the service. Examples of irresponsible use of the system may include failure to attend appointments or repeat booking and cancelling of appointments. I understand the practice is committed to protecting my privacy online. The personal information I enter on this website is strictly controlled using a secure website. Information entered is available only to members of staff with appropriate access rights at Rosegarth & Siddal Surgery and is strictly controlled and monitored. ***Personal information will not be shared with any third parties and will NEVER be sold to third parties.***

| | |
|---|---|
| Signature | Date |

### Photo Identification

One of the following forms of **Photo Identification** can be accepted:
Photocard Driving Licence Passport ☐ Bus Pass ☐ NHS/College/School ☐ ☐

To ensure confidentiality we are only able to accept registrations in person – i.e. you cannot give your details to anyone else to register for you.
The following documents **WILL NOT** be accepted as proof of identity: -
Library card - DVD rental card - Health club card - Private rent card - Birth Certificate

## For back office practice use only

| The patient's NHS number | Identity verified by (initials) | Date |
|---|---|---|
| **Method of verification** Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐ | | |
| **Date account created** | **Date passphrase sent** | |
| **Level of record access enabled**<br>**Appointments, Summary Record & Repeat medication** ☐ | **All** ☐ | **Limited parts** ☐ |

## Please do not use the telephone to order your prescriptions

**WHY?**

4 out of every 100 telephone calls contain an error in the information received during a telephone request

When prescriptions are requested over the phone mistakes are more likely due to: -

- Confusion with drug name pronunciation
- Errors made when writing out the request

**Written Requests Allow:**

- Records to be matched more accurately
- Requests to be processed with no interruption from further calls

Rosegarth Surgery
Rothwell Mount
Halifax
**HX1 2HB**
Fax: 01422 349621
**For online services and practice information go to our website:**
**rosegarthsurgery.co.uk**

Siddal Surgery
117 Oxford Lane
Siddal
Halifax
**HX3 9DG**
Fax: 01422 342292
**For online services and practice information go to our website:**
**siddalsurgery.co.uk**

**The Rosegarth Practice**

# HOW TO ORDER YOUR PRESCRIPTIONS

**Patient Information Leaflet**

**What is a repeat prescription?**

- If you are taking medication regularly, long-term then the doctor may decide that you do not need to see him/her each time you need a new supply of medicines. The doctor will add the medicine you need regularly to your records as a "repeat drug", which you can order when your medicine is running low

- If you have medicines on repeat you will be issued with a "repeat request slip" attached to your prescription otherwise items will remain on 'acute' but can be requested in the usual way.

- Before you ask for a repeat prescription, please STOP and THINK, are you still using ALL the medication on your repeat prescription? If not then please inform the surgery.

**Requesting a prescription**

**Using the repeat request slip**

- Tick the box(es) next to the prescription item you will require within the next ten days

- If you do not have a repeat slip, a request form can be obtained and filled in at reception.

- If you are ordering dressings, catheters or ostomy bags then it is useful to the receptionist if you give the code/reference number

**Using online services**

- If you want to register to view and request medication online from our Practice website, please speak to a receptionist.

**Please do not order your medicines if you already have enough supply for two weeks or more unless there are exceptional circumstances**

- You can deliver, post, fax or order your medication using online services **(see details overleaf)**

- The surgery will take a maximum of 2 working days to process your request and issue a prescription which can then be collected at the surgery

**Many pharmacies offer a medicines collection and delivery service. Ask your pharmacist for more information**

- If you wish the prescription to be sent directly to the pharmacy then please indicate the appropriate pharmacy on the request form **or ask your local pharmacy to set up a nomination so they receive your prescription electronically**

- After receiving items on repeat prescription for a length of time, the doctor may request that you make an appointment to attend the surgery for a medication review with either a doctor or a nurse

**What is a medication review?**

- Medication reviews are important to ensure that your medicines and doses are appropriate and that you are not experiencing any unwanted side effects

- It is important that you attend review appointments even if you feel well and are happy with your medicines in order for the doctor to monitor your progress

- If you are asked to attend the surgery for a review then no further prescriptions will be issued until you have attended the review appointment

***Please do not use urgent appointments for a medication review***