

# THE WYCLIFFE MEDICAL PRACTICE

Thank you for applying to join The Wycliffe Medical Practice. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **Please supply two forms of identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Fields marked with an asterix (\*) are mandatory.

*Title	*Surname
*Any previous surname(s)	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
Town and country of birth	
Home telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Work telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No

*First names
*Date of Birth
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address & Postcode
*Previous address & Postcode
Email address

*Previous GP Details
<b>(for women only)</b> Have you had a cervical smear? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please state where, when and the result if possible)</i>

If you are from abroad please tell us your first UK address where registered with a GP:
If previously resident in UK, date of leaving:
Date you first came to live in UK:
Marital Status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

## Additional details about you

What is your ethnic group?			
<b>White</b>	<input type="checkbox"/> British	<input type="checkbox"/> Irish	
<b>Black</b>	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	
<b>Asian</b>	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese
<b>Mixed</b>	<input type="checkbox"/> White + Black Caribbean	<input type="checkbox"/> White + African	<input type="checkbox"/> White + Asian
<b>Other</b>	<input type="checkbox"/> Please specify:		

Main Language Spoken? (E.g. English)
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Have you ever been in the employ of the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Personnel Number:</i> _____ <i>Date Enlisted:</i> _____ <i>Date Left:</i> _____
Are you a dependant of a current serving member of British Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Next of kin \ Emergency contact

Name of next of kin \ Emergency contact
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Relationship to you
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Next of kin \ Emergency contact telephone number(s)
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Next of kin \ Emergency contact address (if different to above)
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## Data Sharing

### Summary Care Record (SCR)

Your SCR is an electronic summary of key medical information taken from your GP medical record. If you need healthcare away from your usual doctor's surgery, your enhanced SCR will provide those looking after you with key information to help them give you better and quicker care. Please refer to 'What is a Summary Care Record' document for more information or visit: <https://digital.nhs.uk/summary-care-records/patients>

Tick this box if you wish to have an enhanced SCR with core and additional information (recommended)

Tick this box if you wish to opt-out of the SCR

### Risk Stratification Preferences

**Risk stratification** is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. The Wycliffe Medical Practice is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data. **For more information please visit our website at [www.wycliffemedicalpractice.nhs.uk](http://www.wycliffemedicalpractice.nhs.uk)**

Tick this box if you wish to opt-out of the Risk Stratification programme

### Enhanced Data Sharing Module (EDSM)

The Wycliffe Medical Practice use a clinical computer system called SystmOne to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use SystmOne. These other services will always ask consent to view your record. **For more information please visit our website at [www.wycliffemedicalpractice.nhs.uk](http://www.wycliffemedicalpractice.nhs.uk)**

### Medical Interoperability Gateway (MIG)

The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care you will be asked if you consent to the care service seeing essential elements of your record.

More information can be found by visiting: <http://www.healthcaregateway.co.uk/products>

Tick this box if you wish to opt-out of the MIG and Enhanced Data Sharing Module

\*Do you consent to receive the following types of communication (if offered) from The Wycliffe Medical Practice?

Email  Yes  No

Mobile phone text messages  Yes  No

Answering machine messages  Yes  No

## Carers Information

*A carer is a friend or family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.*

Are you looked after by someone who's support you could not manage without?  Yes  No

If yes, what is their name and contact number?

Do you consent for your carer to be informed about your medical care?  Yes  No

Do you look after or support someone who couldn't manage without you?  Yes  No

If yes, is this person a patient of The Wycliffe Medical Practice  Yes  No  Don't know

If yes, what is their name?

Are they a:  Relative  Friend  Neighbour

## Medical details

**In order to continue to receive your repeat medications you'll need to make a new patient health check appointment and bring in your last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with your repeat medication list found on the right hand side or a printed prescription.**

\*Are you allergic to any medicines?  Yes  No (if yes please specify)

\*List other allergies / intolerances (i.e. nuts, gluten, pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

### Have you ever had any of the following conditions?

<b>Epilepsy</b>	<input type="checkbox"/> Yes	Year
<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Year
<b>Heart Attack / Angina</b>	<input type="checkbox"/> Yes	Year
<b>Stroke / Mini-stroke (TIA)</b>	<input type="checkbox"/> Yes	Year
<b>Cancer</b>	<input type="checkbox"/> Yes	Year
<b>Rheumatoid Arthritis</b>	<input type="checkbox"/> Yes	Year

<b>Mental Illness</b>	<input type="checkbox"/> Yes	Year
<b>Diabetes</b>	<input type="checkbox"/> Yes	Year
<b>Asthma</b>	<input type="checkbox"/> Yes	Year
<b>COPD (or Emphysema)</b>	<input type="checkbox"/> Yes	Year
<b>Osteoporosis / Bone fractures</b>	<input type="checkbox"/> Yes	Year
<b>Peripheral vascular disease</b>	<input type="checkbox"/> Yes	Year

Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs.

### The Accessible Information Standard (AIS)

Please use this space to tell us about any specific communication needs you have. I.e. needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

### Do you have family history of any of the following?

<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
<b>Raised Cholesterol</b>	<input type="checkbox"/> Yes	Who
<b>Stroke / CVA</b>	<input type="checkbox"/> Yes	Who
<b>Asthma</b>	<input type="checkbox"/> Yes	Who

<b>DVT / Pulmonary Embolism</b>	<input type="checkbox"/> Yes	Who
<b>Breast Cancer</b>	<input type="checkbox"/> Yes	Who
<b>Any Cancer</b> Specify type:	<input type="checkbox"/> Yes	Who
<b>Thyroid disorder</b>	<input type="checkbox"/> Yes	Who
<b>Epilepsy</b>	<input type="checkbox"/> Yes	Who
<b>Osteoporosis</b>	<input type="checkbox"/> Yes	Who

### Please tell us about your smoking habits

Do you smoke?  Yes  No

If Yes, what do you primarily smoke:  
Cigarettes / Cigar / Pipe (please circle)

How many do you smoke a day?

Would you like advice on quitting?  Yes  No

Are you an ex-smoker  Yes  No












When did you quit?

How many did you used to smoke a day?

**Please tell us about your alcohol consumption**

Questions (please circle your answers)	Unit scoring system				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 4 times per week	4+ times 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

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.

1 UNIT	1.5 UNITS	2 UNITS		3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%		 Large glass of wine (250ml) 12.5%		

Do you exercise regularly?  Yes  No

If so – What exercise do you take?

How often?

\*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3<sup>rd</sup> party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3<sup>rd</sup> party.

I give consent for \_\_\_\_\_ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for \_\_\_\_\_ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Please record any additional information about you that you think is important for us to know**

**Electronic Prescription Service (EPS)**

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service, please talk to your pharmacist of choice.

**Would you like to join our Virtual Patient Group?**

**We send our group quarterly newsletters by email and may also ask for feedback on specific services - please write your email address here if you wish to be included:**

**NHS Organ Donor registration**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or
- Kidneys       Heart       Liver       Corneas       Lungs       Pancreas       Any part of my body

**For more information, please visit the website [www.uktransplant.org.uk](http://www.uktransplant.org.uk) or call 0300 123 23 23**

**\*Signed**

**Signed on behalf of patient** (if applicable)  
(e.g. for minors under 16 years old, adults lacking capacity)

**\*Date**

/ / /

**Once you are registered...**

If there are any problems with your registration we'll contact you to clarify any issues, but once your details have been entered into our computerized records...

On-line Services

...You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available by requesting to be registered at reception.

New Patient Health-check

...You will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you should like to take this up.

**FOR OFFICE USE ONLY**

**PHOTO ID**       **TYPE:** \_\_\_\_\_  
(Over 18 only)

**ADDRESS ID**       **TYPE:** \_\_\_\_\_

**ID VERIFIED BY** \_\_\_\_\_

**NAMED GP: DR** \_\_\_\_\_      **PT INFORMED Y/N**