Partners:
Dr A S Jheeta
Dr M D M Welton
Dr H E Van der Linden
Dr K Coleclough

General Practitioners:
Dr Jan Welton
Dr A Lawrence
Dr H Bowler

Trent Vale Medical Practice

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www.trentvalemedicalpractice.co.uk

Welcome to Trent Vale Medical Practice

This pack provides you with all the information and forms relevant to registering with our practice.

Once you have read all the information and have completed the relevant forms, you will need to come into the practice to hand over your completed forms. Our reception staff will then be able to book your initial appointment to see our Healthcare Assistant for your New Patient Check.

As a practice we offer on-line services (see information attached). If you wish to register for this service, you will need to individually bring with you proof of identity. We cannot accept other members of the household providing this for you due to confidentiality of your information. Any of the following can be accepted as proof of address or identity:

- Current driving licence
- Birth Certificate
- Current Passport

If you take regular medication it is very important that you request one month's supply of medication from your current GP surgery before you hand in the registration pack to our reception staff.
If you receive medical certificates (fit notes) for ongoing medical problems you will need to ensure that your current certificate will not run out for at least 2 **weeks before handing your registration pack to our reception team.**

Once we have received your completed registration pack, our reception staff will book your New Patient Check appointment for you, and then register you on to our clinical computer system (please allow 7 days to be registered). You will then be a patient at Trent Vale Medical Practice and your registration with your previous GP will be cancelled, meaning you will no longer be able to use their services.

Please be aware that all new patients at our surgery need to have a New Patient Check appointment before they can be seen by any of our Doctors or Nurses.

Please note that by registering with the practice, you are consenting to us contacting you via post, telephone, text message and e-mail. We use these services for your convenience for medical advice, appointment reminders, invitations, test results and missed appointments. If you do not wish to be contacted by any of these means, please ensure you let the reception staff know when returning these forms and we can then ensure this is recorded once you are registered.

If there are further questions you would like to ask please do not hesitate to ask our reception team who will be happy to help. We are required to provide all patients (including children) with a named GP. As one of our patients you will be allocated a named GP who will have overall responsibility for the care and support that our practice provides to you. This does not prevent you from seeing any GP in the practice as you currently do. Details of your allocated GP will be shown on your New Patient Questionnaire attached.

Should you require any of our information in a different format i.e. Braille, Large Print please ask our reception staff.

Welcome to Trent Vale Medical Practice.

ON-LINE ACCESS INFORMATION FOR PATIENTS

EMIS Patient Access

Trent Vale Medical Practice offers our patients the following on-line services:

- View and request repeat medication
- View, book, and cancel appointments (only routine GP appointments can be booked on-line but all other appointments you have made can be viewed or cancelled)
- View information from your care records

TERMS AND CONDITIONS OF USE

- You will be provided with log-in details so you will need to think of a password that is unique to you
- It is your responsibility to ensure that your EMIS Access details are not used by anyone else
- If you lose your log-in details you can request a user ID reminder and/or password reset from the Patient Access website if you provided an email address and mobile phone number when registering
- The practice does not have access to your password and you should not disclose your password to anyone else. The practice will never request this information from you
- If you have forgotten your password, we cannot reset it for you, we can only cancel your registration and issue a new sign-up document so that you can re-register
- Use of this service is monitored. If we find that a user is abusing the service access may be restricted or stopped fully. Example of inappropriate use are:
    - Booking appointments and not attending for them
    - Booking appointments for other family members using your name
    - Consistently booking inappropriate appointments with the doctor

To Register Individually for EMIS Patient Access:

- Please read and complete the relevant section of the form below and return to reception personally. We cannot accept other members of the household providing this for you due to confidentiality of your information
- You will be required to provide a form of photographic ID to register for this service so please bring this with you. Accepted forms of ID include current driving licence, Birth Certificate or current Passport
- Once we have verified and taken a copy your ID, a document will be printed with your personal log-on details and instructions on how you complete your registration online at home

To Register for Under 16's Access

- Parents / Guardians can request online access for patients who are under 16
- Please complete the relevant section of form below and return to reception. Please provide personal photographic ID as above
- This service will only be made available to parents / guardians who reside at the same address as the patient
- Please be aware that this service will be automatically deactivated once the patient reaches 16 and they will be required to request this personally

To Register on Behalf of an Elderly Relative or Another Patient for Whom You Are A Carer:

- You can request online access for appointments and repeat prescriptions if you are a carer of other patients registered here
- The person you are requesting the information for must give signed consent to this by completing the relevant section of the form below
- The person requesting access must also sign the relevant section of the form and provide photographic ID when returning the form to reception

ONLINE ACCESS REGISTRATION FORM

(To be scanned to medical record)

Please carefully read the statements below, complete the relevant section of the form and sign where indicated - one form per individual patient must be completed

I confirm that:

- I have read and understood the information leaflet provided by the practice
- I will be responsible for the security of the information I see and download
- If I choose to share my information with anyone else, this is at my own risk
- I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
- If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible
- I understand that access will be denied if I abuse this service

I am applying for on-line access to my own records:

Full Name	
Full Address & Postcode	
Date of Birth	
Home Telephone Number	
Mobile Telephone Number	
E-Mail Address	

Signed:…… Dated: ……

I am applying for on-line access for a patient under 16 years of age and confirm I reside at the same address:

Patient Full Name	
Full Address & Postcode	
Patient Date of Birth	
Parent / Guardian Full Name	
Home Telephone Number	
Parent / Guardian Mobile Telephone Number	
Parent / Guardian E-Mail Address	

Signed:…… Dated: ……

PARENT / GUARDIAN

I am applying for on-line access for an elderly relative or patient whom I care for:

Patient Full Name	
Patient Full Address & Postcode	
Patient Date of Birth	
Patient Home Telephone Number	
Patient Mobile Telephone Number	
Patient E-Mail Address	
Full Name of Person Applying	
Relationship to Patient	
Mobile Telephone Number	
Home Telephone Number	
E-Mail Address	

Signed:…… Dated: ……
RELATIVE / CARER

I give consent for my relative / carer noted above to access to on-line services on my behalf

Signed:…… Dated: ……
PATIENT

New Patient Questionnaire

YOUR ALLOCATED REGISTERED GP IS DR JHEETA

Please complete all parts of this form to help us to deliver the best quality health care to you. We cannot register patients with incomplete information.

PERSONAL DETAILS	
Title: Miss/Ms/Mrs/Mr/Dr Full Name:	Date of Birth: Do you look after someone? Yes ☐ No ☐ (Do you look after a relative/friend/neighbour) Does someone look after you? Yes ☐ No ☐
Full Address: Postcode:	Home Telephone No: Mobile No: Work Telephone No: E-Mail address:
Place and country of birth:	First language spoken:
Ethnicity: British / Mixed British / Irish / White & Black Caribbean / White & Black Asian / White & Black African / Indian or British Indian / Pakistani or British Pakistani / Caribbean / African / Chinese / Other White Background / Other Mixed Background / Other Black Background / Other ***(please circle which applies).***	

PREVIOUS G.P. DETAILS	
Name and address of previous G.P:	Have you previously been registered at Trent Vale Medical Practice? Yes/No

MEDICAL HISTORY **Do you have? ……..**		
	Have now	**Had in the past, please indicate when**
Heart disease or Heart Attack		
Asthma		
High Blood Pressure		
Diabetes		
Stroke or TIA		
Epilepsy		
Underactive Thyroid		
Chronic Pulmonary Disease/COPD		
Mental Health Problems *(please indicate what kind e.g. anxiety, depression, schizophrenia, alcoholism, drug addiction etc)*		
Cancer *(please state which kind and when diagnosed)*		

Please list any other health problems you have below, including any operations and dates if known.

MEDICATIONS **If your taking regular medication please provide the surgery with a copy of your repeat**

medication slip from your previous G.P. we can take a photocopy of this.

FAMILY HISTORY – Please circle if any family member (grandparents/parents/siblings) have suffer(ed) from the following:

Heart Attack / Angina / Raised Blood Pressure / Raised Cholesterol / Diabetes / Asthma / Stroke / Breast Cancer / Ovarian Cancer / Blood Clots (DVT or Pulmonary Embolus)

LIFESTYLE

Smoking Status – please tick which statement applies to you:-

Never Smoked ☐ Current Smoker ☐ **(**please state quantity per day) ……..
Stopped Smoking ☐ (please state quantity per day) .....

PLEASE NOTE – SMOKING IS BAD FOR YOUR HEALTH. PLEASE ASK AT RECEPTION FOR SMOKING CESSATION INFORMATION TO ASSIST YOU TO GIVE UP

Alcohol
What is your average weekly consumption of alcohol?

Wine……..…..units Beer……..…..units Spirits……...units

How often do you have a drink containing alcohol? Please tick which statement applies to you:-

Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐

How many standard drinks containing alcohol do you have on a typical day? Please tick which statement applies to you:-

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐

How often do you have six or more drinks on one occasion? Please tick which statement applies to you:-

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

FOR INFORMATION ON THE RECOMMENDED SAFE LIMITS OF ALCOHOL DRINKING PLEASE ASK AT RECEPTION FOR A LEAFLET. IF YOU FEEL YOU ARE DRINKING ABOVE SAFE LIMITS AND ARE FINDING IT DIFFICULT TO CUT DOWN PLEASE MAKE AN APPOINTMENT WITH A DOCTOR OR PRACTICE NURSE

Exercise

PLEASE TELL US THE TYPE AND AMOUNT OF PHYSICAL ACTIVITY INVOLVED IN YOUR WORK. **Please tick one box only**

I am not in employment (e.g. retired, retired for health reasons, unemployed, full time carer) ☐

I spend most of my time at work sitting (such as in an office) ☐

I spend most of my time at work standing or walking. However my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder) ☐

My work involves definite physical effort including handling of heavy objects and use of tools (eg plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery worker) ☐

My work involves vigorous physical exercise activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector etc) ☐

DURING THE LAST WEEK HOW MANY HOURS DID YOU SPEND ON EACH OF THE FOLLOWING ACTIVITIES? **Please answer whether you are in employment or not**

Physical exercise such as swimming, jogging, aerobics, football, tennis, gym, workout, etc

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Cycling, including cycling to work and during leisure time

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Walking, including walking to work, shopping for pleasure etc

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Housework/Childcare

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

Gardening/DIY

None ☐ Some but less than 1 hour ☐ 1 hour but less than 3 hours ☐ 3 hours or more ☐

HOW WOULD YOU DESCRIBE YOUR USUAL WALKING PACE? **Please mark one box only.**

Slow pace ☐ Steady average pace ☐ Brisk pace ☐ Fast pace ☐

FOR INFORMATION ON HOW PHYSICAL ACTIVITY CAN IMPROVE YOUR HEALTH PLEASE ASK AT RECEPTION FOR A LEAFLET

Diet

Please tick which statement applies to you:-

Vegetarian ☐ Vegan ☐ Weight reducing diet ☐ Low fat diet ☐ Low salt diet ☐ Milk free diet ☐

Egg free diet ☐ High fibre diet ☐ Other ……..

FOR INFORMATION ON HOW A HEALTHY DIET CAN HELP PREVENT OR REDUCE THE SEVERITY OF DISEASES SUCH AS HEART DISEASE, STROKE OR DIABETES, AND HOW TO COMBAT OBESITY AND HELP WITH WEIGHT LOSS PLEASE ASK AT RECEPTION FOR A LEAFLET

ALLERGIES

Please list below any allergies you have

Name of allergen/medication	**What happened (rash/breathlessness etc)**

FOR WOMEN ONLY

If you are using contraception please list it below:-

Type of contraception	How long used	How much do you have left?

If you are taking the pill please state if you have ever had any of the following:-

Migraine	Yes/No	Breast Cancer	Yes/No
Blood Clots	Yes/No	Liver Disease	Yes/No
Family history of breast cancer	Yes/No	Family history of blood clots	Yes/No

Long-acting Reversible Contraception - Please ask for a leaflet or see the nurse if you would like to consider any of the following forms of contraception as an alternative to regular pill taking:-

Intra-uterine system or coil (Mirena) Depot injection contraceptive Implant contraceptive

Many thanks for taking the time to complete this questionnaire. Please ensure that you have answered ALL the questions before handing in at reception. Please sign below to confirm the information you have provided is complete and accurate and that you consent to being contacted by any means used by the practice

Signed: …… Dated: ……

Summary Care Records

The Summary Care record was introduced by NHS England which will be used in emergency care.

The records will contain information about any medicines you are taking, allergies your suffer from and bad reactions to medicines you had had, to ensure those caring for you have enough information to treat your safely.

Your Summary Care Records will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

- **Yes** – I would like a Summary Care Record- You do not need to do anything and a Summary Care Record will be created for you.
- **NO –** I do not want a Summary Care Record – Please complete the below form and hand back to reception

If you need more time to make your choice you should ask our reception staff

For more information talk to our Reception staff or visit **www.nhscarerecords.nhs.uk**

You can choose not to have Summary Care Records and you can change your mind at any time by informing our reception staff.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created unless their parents to guardian choose to opt out.

If you do not want a Summary Care Record please complete this form and hand back to our reception staff.

Section A

Title_____ Surname/Family Name_____

Forename(s) _____

Address _____

Postcode_____ Phone no_____ Date of Birth _____

NHS Number (if Known)_____

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

Section B

Your Name_____

Your signature_____

Relationship to patient _____

Date _____