

## NUNWELL SURGERY

10 Pump Street Bromyard Herefordshire HR7 4BZ Tel: 01885 483412 Fax: 01885 488739

**Partners:** Dr L J Mottram, Dr A M Garner,

Dr H Deer, Dr J Goodman, Dr R Walthew **Practice Manager:** Vanessa Hargest

NHS number: Title: Given Name: Surname: D.O.B: Email:	<p><b><u>If you are registering a child that is under 5</u></b></p> Mother's Surname: Mother's Forename: Father's Surname: Father's Forename: Previous Address of child:  Address of previous GP:  Previous H.V : Telephone Number: Address:
Next Of Kin: Relationship: Address: Postcode: Telephone Number: Emergency Contact?(please circle): YES NO (Info will be added to your records if completed)	<p><b>Electronic Prescription</b></p> I have received information about the electronic prescription service and I would like to nominate the following pharmacy.  Pharmacy Name: Pharmacy Address:
Do you wish to receive <b>text messages</b> from the surgery with appointment reminders and other information relating to your health needs? YES NO	

### ADDITIONAL INFORMATION

<input type="checkbox"/> British or mixed British <input type="checkbox"/> Irish <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian	<input type="checkbox"/> Indian or British Indian <input type="checkbox"/> African <input type="checkbox"/> Chinese <input type="checkbox"/> Caribbean <input type="checkbox"/> Pakistani or British Pakistani	<input type="checkbox"/> Chinese Bangladeshi or British Bangladeshi <input type="checkbox"/> I do not wish to disclose my ethnicity
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Other White Background: _____
Other Mixed Background: _____
Other Asian Background: _____
Other Black Background: _____
Other Ethnic Group: _____

Main Spoken Language:  Religion:  Interpreter required? YES NO	<p><b><u>Communication Needs</u></b></p> Do you have any information or communication support needs?  YES NO
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Have you previously been a member of any of the Armed Forces? YES NO	OR – are you currently a member of any of the Armed Forces? YES NO
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## **ALL PATIENTS HAVE ONLINE ACCESS**

You can book appointments & order repeat prescriptions? Via <https://www.patientaccess.com/>

If you wish to have access to your medical records online please complete attached form.

I consent for my online access details to be posted to me  email

**Please bring proof of identity to register for this service, either a passport, photo driving licence, student card or a household bill over 6 months old.**

**Parents may be able to apply for proxy access for children under the age of 11. Please ask at reception for details**

## **CARERS**

Are you a carer? (Please circle) Yes / No

Name of person you care for:

Their date of birth:

Their relationship to you:

Brief Description of their health condition:

*Please ask reception for an information for Caretrust4all.*

**SMOKING STATUS – Are you a current smoker**

- Ex smoker

-Never smoked Tabacco

## **ALCOHOL SCREENING –**

Enter the total value below

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

*0 points = Never*

*1 point = Monthly or less*

*2 points = 2-4 times per month*

*3 points = 2-3 times per week*

*4 points = 4+ times per week*

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### **How many units of alcohol do you drink on a typical day when you are drinking?**

*0 points = 1-2 drinks*

*1 point = 3-4 drinks*

*2 points = 5-6 drinks*

*3 points = 7-9 drinks*

*4 points = 10+ drinks*

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### **How often do you have 6 or more units if female, or 8 or more if male, on a single occasion in the last year?**

*0 points = Never*

*1 point = Less than monthly*

*2 points = Monthly*

*3 points = Weekly*

*4 points = Daily or almost daily*

*Total /12*

If score more than 5 please book an appointment to see HCA

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### SHARING YOUR DATA

#### Nunwell Surgery – Fair Processing and Privacy Notice

The practice handles medical records in-line with laws on data protection and confidentiality. We share medical records with those who are involved in providing you with care and treatment and in some circumstances for medical research. We also share information when the law requires us to do so.

You have rights with regard to your medical record, for example to have access to it, to object to information held within it, to object to it being shared for direct care or for research or planning.

If you would like more information about how we share information, how to opt-out of sharing or if you would like to view the full privacy notice, please ask at reception. A summary of the privacy notice is on display in the waiting room.

The information on this form helps us to provide you with a full and effective primary medical service and we thank you for completing it. Welcome to Nunwell Surgery, we are pleased to have you as a patient at our practice. You will be invited for a new patient check in order that we can meet you personally, ensure we have the information you need and arrange your medication if necessary.

Please try to attend.

**Patients Signature:**

**Date:**

#### **Admin action only: ADD TO RECEPTION TEMPLATE**

Out Of Area Patient (please circle): Yes / No

"OUT OF AREA REG" added to the registration page

Informed Named Accountable GP:  Initials:

**Allocated AND informed** on reception template

DMS Patient

New patient check offered?

Veteran letter given

Privacy notice given to patient

Identity Checked \_\_\_\_\_

(Record method & Initial) \_\_\_\_\_

Template completed (initial): \_\_\_\_\_ Date: \_\_\_\_\_

#### **Clinician Action (Out Of Area Patients Only):**

GP Checked Notes

Clinically Appropriate (please circle) Yes / No

Clinician Signature: \_\_\_\_\_

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

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### APPLICATION FOR ONLINE ACCESS TO MY DETAILED MEDICAL RECORD

Surname		Date of Birth	
First Name			
Address		Postcode:	
Email Address			
Telephone Number		Mobile Number	

I wish to access my detailed medical record online and understand and agree with each statement

I have read and understood the information leaflet provided by the Practice	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me or is inaccurate, I will contact the Practice as soon as possible	<input type="checkbox"/>
If I think that I may come under pressure to give access to someone else unwillingly I will contact the Practice as soon as possible	<input type="checkbox"/>

Signature:		Date:	
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#### For practice use only

Patient NHS No:		EMIS No:	
Identity verified by:		Date:	
Method:	<input type="checkbox"/> Photo ID or Proof of Residence <input type="checkbox"/> Vouching <input type="checkbox"/> Vouching with Information in Record		
Authorised by:		Coded in Notes: (Code 9RN)	
Date Account Created:			

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Level of Record Access Authorised and Enabled:	<input type="checkbox"/> Appointments <input type="checkbox"/> Prescriptions <input type="checkbox"/> ENTIRE CODED RECORD including documents <u>OR</u> <input type="checkbox"/> - <i>Medical Record – with <u>all</u> coded data</i> <input type="checkbox"/> - <i>Medical Record - <u>Limited</u> - third party or sensitive data restricted (right click on relevant consultations - online visibility – ‘do not display’)</i> <input type="checkbox"/> - <i>Contractual Minimum – consultation/coded data <u>from 1/4/16</u></i> <input type="checkbox"/> * <i>Documents – <u>ALL</u></i> <input type="checkbox"/> * <i>Documents – contractual minimum <u>from 1/3/17</u></i>		
Notes/Explanation:			
Authorising GP Signature		Date	