**Modern Medical Centre**

**NEW PATIENT INFORMATION SHEET**

**WIDER DETERMINANTS QUESTIONNAIRE- please use capitals**

**WHICH BOROUGH TO YOU LIVE IN?** HAVERING BARKING AND DAGENHAM

**Communication**

**Preferred method of contact**..........................................................................................

**Digital Literacy Level (are you able to use a computer?)……………………………………….**

**Literacy**

**Do you have difficulty understanding information provided to you about your health or treatments you may be receiving? (put tick in the box that applies to you)**

 **Yes No**

**Do not wish to provide information on literacy.**

**­­­­­­­­­­­­­­­­­­­­­­­­**

**Lifestyle**

**Would you like help with any of the following: (tick which applies)**

 **Smoking Exercise Healthy Eating**

**Housing**

 Lives alone. Lives alone help available. Lives alone help available.

Lives in Nursing Home. Lives in Residential Home**.**

**Do you have problems with housing?** Yes No

 Homeless single person. Homeless Family. Sofa Surfer (no fixed abode)

Living in Squats Living Rough

**Housing rent – owned.**

House rented from Council Housing Association Private Landlord

House owner No Mortgage House owner Mortgage

**Would you like help with your housing?** Yes No

**Employment and Income**

**Employment status**

Unemployed Employed Retired Student

 **Not in** employment, education or training

**Problems at work** Yes No

Do you have money problems that make it hard to meet your needs? Yes No

**Income Difficulty**

Able to buy on necessities Difficulty buying necessities Low/No income.

**Occupation………………………………………………..**

**Exposure to occupational risk factor** Yes No

Would you like help with building skills, volunteering, or your job**?..........................................................**

Would you like help with managing your money or benefits**?.....................................................................**

Declined to provide information about financial circumstances.

**Other Factors**

**Do you feel lonely Yes No**

**Do you feel lonely and would like help to connect with local groups Yes No**

 **Single Parent**

 **Decline to disclose social isolation status.**

**Social Worker Involved Yes No**

**VISA STATUS**………………………………………………………………….

**ASYLUM SEEKER/REFUGEE STATUS**……………………………………

**The government now ask us to record your ethnicity.**

**Please delete as necessary:**

I **agree/do** not agree to Modern Medical Centre recording my ethnicity.If you agree please tick the appropriate box. This information will be treated in the strictest of confidence.

[ ]British or Mixed British [ ]Other Mixed Background [ ]African
[ ]Irish [ ]Indian or British Indian [ ]Other Black Background [ ]Other White Background [ ]Pakistani or British Pakistani [ ]Chinese [ ]White and Black Caribbean [ ]Bangladeshi or British Bangladeshi [ ]Caribbean
[ ]White and Black African [ ]Other Asian Background [ ]White and Asian
[ ]Other

**PREFERRED SPOKEN LANGUAGE
Please select your preferred spoken language from the list below:**
[ ]English [ ]Welsh [ ]Gaelic [ ]British Sign Language [ ]Makaton Sign Language [ ]Akan [ ]Albanian [ ]Amharic [ ]Arabic [ ] Bengali & Sylheti
[ ]Cantonese [ ]Creole [ ]Dutch [ ]Ethiopian [ ] Cantonese and Vietnamese
[ ]Farsi [ ]Finnish [ ]Flemish [ ]French [ ]French Creole
[ ]German [ ]Greek [ ]Gujarati [ ]Hakka [ ]Hausa [ ]Hebrew

[ ]Hindi [ ]Igbo [ ]Italian [ ]Japanese [ ]Korean [ ]Kurdish [ ]Lingana [ ]Luganda [ ]Malaysian [ ]Mandarin [ ]Pashto [ ]Patois

[ ]Norwegian [ ]Portuguese [ ]Polish [ ]Punjab [ ]Russian

[ ]Serbian / Croatian [ ]Sinhala [ ]Somali [ ]Spanish [ ]Swahili [ ]Swedish

[ ]Syheti [ ]Turkish [ ]Thai [ ]Urdu [ ]Vietnamese

[ ] OTHER \_\_\_\_\_\_\_\_\_\_\_

**ARE YOU A CARER**…………………………………**IF YES TO WHOM**…………………………………….

**DO YOU HAVE A CARER**………………………….**IF YES WHO CARES FOR YOU**……………………..

**NEXT OF KIN NAME**……………………………………**CONTACT NUMBER**……………………………….

**MARITAL STATUS**……………………………………………………………………………………………

**SMOKING STATUS** : SMOKER EX SMOKER NEVER SMOKED ELECTRONIC CIGARETTE

**How many cigarettes do you smoke daily**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOULD YOU LIKE TO GIVE UP SMOKING**…………………………………………………………………..

**BLOOD PRESSURE**………………………………………………………………………….

**ALCOHOL CONSUMPTION**: NON DRINKER DRINK DAILY DRINK RARELY DRINK SOCIALLY

**EXERCISE STATUS**: NO EXERCISE LIGHT EXERCISE MODERATE EXERCISE HEAVY EXERCISE

**WEIGHT**…………………………………………………….

**HEIGHT**……………………………………………………..

**DISABILITIES**: I.E. REGISTERED BLIND, HEARING DIFFICULTY, DEPENDENT ON WHEELCHAIR

 SPEECH PROBLEM,

 OTHER DISABILITY…………………………………………

**ALL HISTORY:**

Have you had any serious illnesses /operations /X-rays or similar tests? When?

…………………………………………………………………………………………………………………………

FAMILY HISTORY: Which of your blood relations have suffered one of the following:-

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Brother / sister | Aged |
| Heart disease / attack |  |  |  |  |
| Cancer |  |  |  |  |
| Diabetes |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Asthma |  |  |  |  |
| TB |  |  |  |  |
| Stroke |  |  |  |  |
| Other Serious Illness |  |  |  |  |

**HISTORY OF ANY MEDICATION**………………………………………………………………………………

**HISTORY OF ANY ALLERGIES IF SO TO WHAT**……………………………………………………………

**WHICH PHARMACY WOULD YOU LIKE PRESCRIPTIONS SENT TO**……………………………………

**FEMALE ONLY QUESTIONS**

**WHEN WAS YOUR LAST SMEAR TEST** ………………………………………………………………………

**WHAT WAS THE RESULT**………………………………………………………………………………………..

**HISTORY OF HYSTERECTOMY**………………………………………………………………………………….

**Have you had any children?** YES / NO How many …………………………………

**Are you currently, or think you may be, pregnant?** YES / NO

**Which method of contraception (if any) are you using at present**? …………………………

ALL PATIENTS:

I confirm that the information given is true to the best of my knowledge

Signed: ………………………………………………. Date: ………………………..

**PATIENT CONSENT FORM**

Consent to hold, process and share manual and electronic records and data in accordance with the Data Protection Act 2018, the Caldicott Report, and other relevant Information Governance legislation.

When you are registered at the practice, your details will be shared, as appropriate:

* With members of the practice health care team
* With other healthcare professionals involved in my care
* For the purposes of practice administration

I give my informed consent for Modern Medical Centre to hold, process and share my personal and medical records, manually and electronically, as outlined below:-

**YES / NO**

Locally for the purposes of the Local Shared Electronic Record (CHIE) and Hub

for my direct health care

**YES / NO**

Nationally for the purposes of National Shared Electronic Record (SCR) for my

direct health care

**YES / NO**

Nationally for the purposes of improving and planning the health and care of

current and future generations (indirect health care)

*If you have any concerns regarding how your information will be used by the practice and others, please see the confidentiality section on our website www.modernmedicalcentre.org*

By providing your contact details, you are consenting to us using them to contact you by post, telephone, email or SMS (text).

We do not share your data for the purposes of education, research, audit or administration without your express consent (i.e. we would ask you every time for permission before doing this). The only exception to this would be where the data was anonymised, i.e. not identifiable back to you.

**Your Appointments & Prescriptions Online**

You can now book, cancel and view your appointments, as well as ordering your repeat medication online. This service is provided through our Clinical Software Supplier (Emis), and is called Patient Access.

If you are interested in this service, you will need to complete the registration Form below and come to the surgery with an appropriate form of photo ID (such as a Passport or Driving License). *Please note: each family member 16 and over will need to visit the surgery with their own Photo ID.*

Please complete the form below **clearly** and in **BLOCK CAPITALS.**

**I wish to register for** Patient Access**:**

|  |  |
| --- | --- |
| **Forename:**       | **Surname:**       |
| **Date of Birth:**       |  |

*At present patient under 16 are not able to register.*

|  |  |
| --- | --- |
| **Email address:**       | **Home telephone number:**       |
| **Mobile telephone number:**       | **Work telephone number:**       |

*By providing your email address / mobile phone number, you consent to the surgery using it to communicate with you regarding your healthcare. It will not be shared with any other companies, and you can opt out of* Patient Access *and communication by email / SMS at any time by contacting the surgery.*

*The surgery does not recommend that patients use a shared email address / mobile phone number – you will be sent appointment booking and prescription confirmation emails, which may be confidential to the individual. By choosing to use a shared email address / mobile phone number, you confirm that you are aware of this issue and accept the consequences. For more information, please contact the surgery.*

**PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO KEEP US INFORMED IF YOUR EMAIL ADDRESS OR TELEPHONE NUMBERS CHANGE.**

|  |  |
| --- | --- |
| **Signed** | **Date** |
|  |       |

**Staff Use Only:**

|  |  |  |
| --- | --- | --- |
| **Type of ID Seen** | **ID Seen By** | **Date ID Seen** |
|  |  |  |

**TO REGISTER AT THIS PRACTICE PLEASE READ CAREFULLY THE FOLLOWING AND SIGN BELOW**

1. The practice provides all NHS services under the New General Medical Services contract.
2. We will be courteous to you and in return expect you to be courteous to members of staff. Any form of verbal or physical abuse will NOT be tolerated.
3. Book one 10 minute appointment per problem. If you have more than one problem to discuss, please make at least a double appointment (20 minutes). Doctors will be forced to reinstate if you bring many problems within a 10 minute slot.
4. If other members of your family need to see the Doctor, please make a separate appointment. This will help us to run on time with the appointment system
5. If you change your address or telephone number please tell us straight away, in order to validate our records and to promptly contact you if the need arises.
6. 48 hour notice is required in writing for repeat prescriptions. Under no circumstances will requests for repeat medication be accepted over the telephone to avoid any prescription errors. Please use a self-addressed stamped envelope if you need your prescriptions posted to you. All repeat medication should be ordered well in advance and not when you run out of medication.
7. For out of hours emergencies, call 111 (free of charge) and follow instructions or call the surgery number and listen to the message carefully and act accordingly. Do not call if it is NOT an emergency, you can wait until the surgery opens.
8. To speak to a clinician or inquire about your results, please call between the hours of 12.30pm and 1.30pm Monday to Friday. If it is urgent call after 9am on telephone number 01708 747147.
9. All non-NHS services will incur charges depending upon the service required. Please confirm fee with the receptionists and make payment promptly.
10. CCTV 24 hour’s video surveillance is in operation and your attendance in the Reception/ waiting area will be recorded for safety reasons.
11. For temporary and emergency patients, once the limit of 3 months expires it is not possible to renew the temporary registration.
12. SMOKING IS NOT permitted in the surgery and its premises.
13. DO NOT bring food or drink into the surgery building.
14. Children should be looked after by their parents/ carers in order to avoid any inconvenience to other patients and smooth running of our service.

**PLEASE NOTE WITHOUT SIGNING YOU WILL NOT BE REGISTERED AT THIS PRACTICE.**

**I AGREE TO COMPLY WITH ALL THE ABOVE CONDITIONS FOR MY REGISTRATION AT THE MODERN MEDICAL CENTRE, ROMFORD, RM7 0PX.**

**Full name: …………………………………………………………………………………………………………**

**Signature: …………………………………………………… Date: ……………………………………………**

**WE WELCOME YOU AS A PATIENT AND THANK YOU FOR JOINING OUR PRACTICE**