Hastings & Rother Healthcare

New Patient Registration Form Adult

About Hastings & Rother Healthcare

Hastings & Rother Healthcare is a three-surgery partnership, which consists of Churchwood Medical Practice, Hastings Old Town Surgery, and Warrior Square Surgery, providing general medical services to a patient list of approximately 25,000 patients in Hastings & St Leonards.

Hastings Old Town Surgery
The Ice House
Rock'A'Nore road
Hastings
TN34 3DW
01424 452800

Churchwood Medical Practice
Tilebarn road
Hastings
TN38 9PA
01424 853888

Warrior Square Surgery
Marlborough House
19-21 Warrior Square
Hastings
TN37 6BG
01424 434151

Please complete this confidential questionnaire in **BLOCK CAPITALS** and tick boxes as appropriate.	Date completed:

Title: (Mr, Mrs, ect.)		**Date of Birth:**	
Forename:		**Calling Name:**	
Surname:		**Previous Surname:**	
Current Address:		**Previous Address:**	
Ethnicity:		**First Language:**	
Marital Status:			
Email Address:			
Occupation:			
Next of kin details:	Title: Surname: Forename: Relationship: Address: Telephone numbers:		

Next of kin able to discuss medical records?	Yes: ☐ No: ☐
Special circumstances:	Please tick if any of the following apply: • I have a carer ☐ • I am a carer ☐ • Asylum seeker ☐ • Housebound ☐ • Live in a nursing home ☐ • Live in a residential home ☐ • Live in a community psychiatric home ☐ • Live in a children's home

If you have ticked any of the above, please provide more information:

Are you: **Registered blind or partially sighted** **Registered deaf** **Registered disabled**	Please state which of these apply:

Height:		**Weight:**	

Allergies:		**Disabilities:**	

Do you have any drug allergies? *Please include known reactions*	
Do you suffer from any of the following: **Heart disease** **Hypertension** **Asthma** **Diabetes** **COPD** **Chronic kidney disease** **Epilepsy** **Stroke** **Cancer**	Please state which of these apply and give date of last review:
Do you have any other serious or chronic illness?	Please explain:
Do you have a family history of: **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer**	Please give details including relationship, illness and age at diagnosis if known:

Have you had any significant injuries or major operations?	If yes, please give details:
Smoking status – Are you: **A current smoker** **An ex-smoker** **A non-smoker**	If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker please give the date you stopped (month/year).
How many units of alcohol do you drink on a typical day when you are drinking? (1 unit = ½ a pint or a small glass of wine or a single pub measure of spirits)	Please tick which applies: 1-2 3-4 5-6 7-9 10+
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Please tick which applies: Never Daily Weekly Monthly Less often than monthly

Alcohol scoring system	0	1	2	3	4	Score

How often do you drink alcohol	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when drinking?	1-2	3-4	5-6	7-9	10+	
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Never	Less often than monthly	Monthly	Weekly	Daily or almost daily	

Current medication	If possible, attach a copy of your repeat prescription list.		
Medication	Dosage	Repeat	Quantity remaining

Females only:	
Date of last cervical smear	
Contraception used	
Over 65s:	
Have you had a pneumonia vaccine in the last 10 years?	
Have you had a flu vaccine this year?	
Please use this space to give any other information you feel is appropriate:	

ACCEPTABLE BEHAVIOUR CONTRACT

At Hastings & Rother Healthcare, we are committed to providing you with the best level of care and service. An acceptable behaviour contract is an individually written agreement between a patient and their GP practice in order to maintain a healthy relationship.

The contract is between:

Print name:	
Date of birth:	

And Hastings & Rother Healthcare, and is valid from the date shown in the signature table below.

The surgery aims to:

- Help you as a patient to access our services, or sign post you to the most appropriate services based on your requirements
- Provide you with support as quickly and fairly as possible
- Be polite, respectful and helpful to you

In return, we expect you as a patient to:

- Treat staff fairly and politely, whether on the phone, face to face, in writing, or on social media
- Use our complaints policy if you need to raise concerns about our care or service

- Attend your appointments, giving at least 2 hours' notice if you are unable to attend
- Allow us up to five working days' to process any repeat prescriptions that you require

In order for us to maintain a safe and orderly surgery, the following processes have been set out to protect staff and patients alike:

- Any abusive, threatening or violent behaviour will be assessed and managed either by a final warning letter, 8-day removal or immediate removal from the practice list
- Failure to attend appointments will be managed by a three stage warning process, as per our Did Not Attend policy, which may result in removal from our practice list
- Each incident will be assessed on a case by case basis in order to provide a standard of fairness and any necessary safeguarding measures

Declaration: I confirm that I understand the reason of this contract and the consequences of breaking the conditions of the contract.

Signature	
Date	

Information for new patients: about your Summary Care Record

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

a. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

a. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

a. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of Patient:

……

Address:

……

……

Postcode: …… Date of Birth:

……

NHS Number (if known):
……..

Signature: …….. Date:
……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name:
……
.....

Please circle one: Parent Legal Guardian Lasting power of attorney
for health and welfare

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

COMMUNICATION CONSENT FORM

I consent to the practice contacting me by text message and/or email for the purposes of health promotion, practice news and for appointment reminders.

I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

Please tick the box to give consent: ☐

I CONSENT to the practice contacting me by text message for the purpose of health information and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession

Patient name:	
Date of birth:	
Mobile number:	

Email Address:	
Signature:	
Today's date:	

We will NOT send out any texts unless you have explicitly consented.

PATIENT DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.