**BELLEGROVE SURGERY**

**NEW PATIENT INFORMATION SHEET**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |  | | |  | | | |
| First Name(s): |  | | | Surname: |  | | |
| Date of Birth: |  | | | Gender: | Female  Male | | |
| Full Address: |  | | | | | | |
| Tel No Home: |  | Tel No Work: |  | | | Mobile  No: |  |
| Consent to leave message:  Y  / N | | Consent to leave message: Y  / N | | | | Consent to leave message:  Y  / N | |

**UNDER 18'S SECTION**

We will require immunisation data for all children. If you could, please bring your child's red book or immunisation card/booklet if immunised outside of the UK for photocopying at the time of registering

**COVID VACCINATION STATUS**

If given abroad please state where and provide copy of certificate(s)/vaccination card(s)

|  |  |  |  |
| --- | --- | --- | --- |
| **1st Dose**  Given in UK abroad | Date: | **2nd Dose**  Given in UK abroad | Date: |
| Name: | Name: |
| **3rd Dose (if applicable)**  Given in UK abroad | Date: | **Booster Dose**  Given in UK abroad | Date: |
| Name: | Name: |
| **Spring Booster**  Given in UK abroad | Date: | Covid vaccine declined |  |
| Name: |

**Have you had any Operations?**

|  |  |
| --- | --- |
| Operation: | Date of Operation: |
|  |  |
|  |  |
|  |  |
|  |  |

**FAMILY HISTORY -** which of your blood relations have suffered from the following?

|  |  |
| --- | --- |
| **Condition:** | **Relationship:** |
| Heart Attack |  |
| Diabetes |  |
| Asthma |  |
| Stroke |  |
| High Blood Pressure |  |
| Cancer |  |
| Tuberculosis |  |
| Other serious illness – please state |  |

**FEMALE PATIENTS ONLY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you currently pregnant? | | | | Yes | |  | LMP  &  EDD | | |  | No |  |
| If pregnant, which hospital are you booked in with? | | | |  | | | | | | | | |
| Have you had the 28 weeks + Whooping Cough vaccine? | | | Yes | |  | | | Date | |  | No |  |
| Have you had any children via Caesarean? | How many? |  | | Date of birth for each child | | | | |  | | | |
| Have you had any children via normal delivery? | How many? |  | | Date of birth for each child | | | | |  | | | |
| Have you had a miscarriage? | | | | Date(s): | | | | |  | | | |
| Have you had a termination of pregnancy? | | | | Date(s): | | | | |  | | | |
| Have you had a hysterectomy? | | | | Date: | | | | |  | | | |
| Which method of contraception are you using at present? | | | | | | | | |  | | | |

**TO BE COMPLETED AT HEALTH CHECK APPOINTMENT:**

|  |  |  |  |
| --- | --- | --- | --- |
| Weight: |  | Height: |  |
| BP |  | Pulse |  |
| Diet |  | Exercise: |  |
| Urine: | Protein = | Urine: | Glucose = |
| Mobility: | Do you use a walking aid?  eg walking stick | Yes  No | |
| Eyesight: | Do you wear glasses/contact lenses? | Yes  No | |
| Eyesight | Do you have an eye condition? | Yes  No  If yes, please provide details: | |
| Hearing: | Do you have a hearing impairment, implant or aid? | Yes  No  If yes, please provide details | |
| Other Information: |  |  | |

|  |  |  |
| --- | --- | --- |
| Clinicians signature: |  | Dated: |

**Bellegrove Surgery**

**PATIENT CARE TEXT MESSAGING**

**CONSENT FORM**

**Declaration**

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all/or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

Text messages are generated using a secure facility however 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.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

**Patient name ………………………………….. Date of Birth ………………….**

**Date …………………………**

*The practice does not share mobile phone contact details with any external*

*Organisation*

**BELLEGROVE SURGERY PMS PRACTICE**

**Dr William A. Cotter 174 Bellegrove Road**

**MA, MB, BCh, BAO, DFFP, MRCGP Welling**

**Dr Jacqueline C.J.M. Bohmer-Laubis Kent DA16 3RE**

**Dr, Drs, DFFP, DPD Tel: 020 8856 1770**

**Dr Amaya Foces Appts: 020 8856 1770 option 1**

**LMS, DFFP** [**bellegrove.surgery@nhs.net**](mailto:bellegrove.surgery@nhs.net)

**NHS ZERO TOLERANCE TO VIOLENCE**

I fully understand that the NHS is operating a permanent zero tolerance policy towards violence and abusive behaviour (this also includes harassment, alarming, distressing, threatening, abusive or insulting behaviour as well as violent behaviour) by any individual. This policy applies to all Health Service facilities including all areas of general practice/primary care.

I further understand that should I be a party to violent, threatening or abusive behaviour towards any member of staff of a primary care facility, then I will expect that certain sanctions will be applied to me. This could include removal from the general practitioners medical list, along with my family or being seen at an approved secure centre for violent patients.

I am aware that difficulties may occur in the provision of my medical care that cannot be the responsibility of any one Healthcare Professional. I am also aware that violent, threatening or abusive behaviour cannot alter this situation, which is often beyond the control of the individual professional.

I agree that on becoming a patient on the medical list of a doctor within the surgery. I will not use any form of violent, threatening or abusive behaviour towards any member of the staff at any one time.

NAME…………………………

Signed …………………………

Date …………………………

**

**CONFIDENTIAL**

**OPT-OUT FORM**

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**Request for my information not to be available to view in Connect Care**

----------------------------------------------------------------------------------------------------------------What does it mean NOT to have a Connect Care Record?

The staff caring for you may not be aware of your current medications and allergies, or other important information about your health and care. Your information will continue to be shared by letter, email, fax or phone. You can change your mind at any time and opt back in.

---------------------------------------------------------------------------------------------------------------- If you **DO NOT** want your information to be viewed in Connect Care please fill out the form and return it to “FREEPOST LGT” (please make sure that you write this in capitals). **Forms sent anywhere else will not be actioned.**

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If you have any questions, or if you want to discuss your choices before completing this form, please call 020 8314 0481 and leave your name and number for someone to contact you, or visit the **website www.lewishamandgreenwich.nhs.uk/connectcare**.

---------------------------------------------------------------------------------------------------------------- **Please complete the PATIENT DETAILS in BLOCK CAPITALS**

Title: ........................................... Surname / Family name: ......................................................

Forename(s):.................................................................................................................................

.

Address:........................................................................................................................................

Postcode: ......................................................................... Phone No: ………………………….

Date of birth: ....................................................NHS Number (if known): .................................

I am the person named above.

The person named above is under 16 and I am their legal guardian / have parental responsibility.

The person named above does not have capacity to give consent and I have lasting power of attorney. I request that my / their information is not available to view in Connect Care and that no Connect Care record be available to assist in treating me / them, even in an emergency situation. I confirm that I have read the “Deciding not to have a Connect Care record” information sheet and that I understand the consequences of taking this action and have carefully considered the implications of this for my / their health and care.

Signature: ......................................................... Date: ................................................................

Relationship to person/child: ………………….Phone No: ...................................................... ----------------------------------------------------------------------------------------------------------------