**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 | |

**CHILDHOOD VACCINATIONS -** which vaccinations have you had and when?: **PLEASE BRING RED BOOK (OR EQUIVALENT) FOR PHOTOCOPYING**

**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: |

**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 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**

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**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 …………………………



**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: ………………………………………………..….........................

Date of birth: …………………………… Patient’s postcode: …………………

Surgery name: …………………………… Surgery location (Town): ………..................

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 |

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

To update the patient’s consent status, use the SCR consent preference dialogue box and select the

relevant option or add the appropriate read code from the options below.

|  |  |  |
| --- | --- | --- |
| **Summary Care Record consent preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (express consent for  medication, allergies and adverse reactions only) | 9Ndm. | XaXbY |
| The patient wants a Summary Care Record with core and additional  information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn. | XaXbZ |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo. | XaXj |

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