Welcome to

WEST MOORS VILLAGE SURGERY

175 Station Road West Moors BH22 0HZ
Telephone 01202 865800

NEW PATIENT QUESTIONNAIRE

When returning your completed form/s you will need to bring in photographic proof of identification, e.g. passport or driving licence. Please also bring in original documents to provide identification of your address, i.e. utility bill.

Parents of patients under age 16 are required to submit the child's birth certificate which will be photocopied so that parental responsibility can be noted on the child's record. If parental responsibility changes after registration it is the parent/s with responsibility duty to advise us.

Are you a patient who is not ordinarily resident in the UK? Please ensure you complete the reverse of the GMS1 form.

On registration you will be allocated a named GP, to find out who this is please contact the Practice 21 days after registering. If you have a preference as to who your named GP is, we will make reasonable efforts to accommodate your request. Please remember that although your named GP is responsible for your overall care, you are still able to see any GP of your preference.

PATIENT: I confirm that the information I have provided is true to the best of my knowledge:		
Signature of Patient or Patient Representative:	**Print Name:**	**Date:**

RECEPTION ONLY: Child ID – A child's birth certificate is required to be photocopied and attached to this pack. Adult ID is not required to be photocopied if the boxes below are completed.			
		Seen by:	**Date:**
Child Birth Cert or Passport:	**Attach copy to Registration Pack**		
Photo ID Type seen:			
Address ID Type seen:			

Communication with You

Please complete as many of the following as are applicable to you:

Home Telephone:	Mobile Telephone:
Work Telephone:	Fax Number:
Email Address:	
Letter to home address as detailed on page one.	
Letter to other correspondence address, please write address here:	

Please indicate your preferred communication method by circling one of the above.

The practice aims to ensure that disabled people have the communication support they need. If you would like this form or information – and subsequent information – sent to you in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know.

Please select the format that would suit you best:

Braille:	Large Print:
Audio Tape:	Easy Read:
British Sign Language: Other Sign Language:	Other: Please Specify:

If you have a carer does this person need to specify a preferred method of communication and/or an alternative communication format? Please advise their contact details on the Carers Information box on page two of the registration forms and write their name above where applicable. If you are a parent or guardian of a patient and you would like to specify a preferred method of communication and/or an alternative communication format, please let us know.

Please note: It is your responsibility to ensure the above information is kept up to date on our records and that when used the method of communication is secure for patient confidential information.

Emergency contact information Please advise of a contact outside your house-hold, if possible.

Name: Title/Given Name/Family Name: _____

Gender: _____ Relationship to patient: _____

Telephone Numbers: Mobile/Landline: _____

Is this person your **NEXT OF KIN**? If not, please advise your next of kin:

Name: Title/Given Name/Family Name: _____

Gender: _____ Relationship to patient: _____

Telephone Numbers: Mobile/Landline: _____

CARERS INFORMATION

Do you look after someone?

Full name of person being cared for: _____

Your relationship to this person: _____

Reason why caring is required: _____

Does someone look after you?

Full name of your carer: _____

Telephone Number: _____

Mobile: _____

Reason why caring is required: _____

SMS TEXTING – sign if you do NOT wish to receive texts

*To **Opt Out** of Receiving Appointment Reminders by SMS Text Message*

We would like to use our SMS text reminder service to, for example, send you a reminder via your mobile phone approximately 24 hours before your appointment is due.

If you would **NOT** like to use this service please sign and date below:

Signature: _____ Date: _____

ELECTRONIC PRESCRIPTION SERVICE

The Electronic Prescription Service (EPS) is an NHS Service. It gives you the chance to change how your GP authorises your prescription.

If you currently collect your repeat prescription from your GP you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to our local pharmacy Moors Pharmacy, or you can designate a pharmacy of your choice. You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive. To authorise this process, please sign and date below - if this is not Moors, please advise the pharmacy name and address.

Signature: _____ Date: _____

Pharmacy Name-Address: _____

WHICH ETHNIC BACKGROUND DO YOU REPRESENT:		
White British	White Irish	Any Other Ethnic Group
Mixed White & Black Caribbean	Mixed White & Black African	Mixed White & Asian
Asian or Asian British Indian	Asian or Asian British Pakistani	Asian or Asian British Bangladeshi
Black or Black British Caribbean	Black or Black British African	Chinese
First spoken language:	Do you need an interpreter? **Y/N**	

ARE YOU AN ARMED FORCES VETERAN?

Of which service are you a Veteran?	
Date enlisted and date discharged	

YOUR OCCUPATION: – please circle most appropriate:

Employed – Self Employed – Retired – Unemployed – Other

If employed or self-employed, please specify job role:

YOUR DETAILS

How tall are you? ft in *or* centimetres What do you weigh? st lbs *or* kilos	**Do you smoke?** Have you ever smoked Yes ☐ No ☐	I am a current non-smoker – gave up in:date:
	I smoke: _____ cigarettes per day _____oz pipe tobacco per day _____cigars per day	
	I would like to give up smoking, please send me contact info: Yes ☐ No ☐	

ALLERGIES – SENSITIVITIES Are you allergic to any medication? (*If so please state)*

FAST ALCOHOL SCREENING TEST (FAST)

MEN: How often do you have EIGHT or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
WOMEN: How often do you have SIX or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, on one occasion	Yes, on more than one occasion	-	-	

WEST MOORS VILLAGE SURGERY
PATIENT INFORMATION LEAFLET

SUMMARY CARE RECORD SHARING
SYSTMONE RECORD SHARING

Introduction

This leaflet explains why we collect information about you, the ways in which this information may be used and who we may share this information with to help care for you.

Why we collect information about you and what records do we keep

To provide you with the best quality care possible, we must keep health records about you. These contain information about the treatment and support you receive which is recorded by the professionals who have been involved in your care. This may include:

- basic details about you such as address, date of birth, next of kin;
- any contact we have had with you such as clinical visits;
- notes and reports about your health;
- details and records about your treatment and care;
- hospital letters;
- results of x-rays, laboratory tests etc.;
- any other relevant information from people who care for you and know you well such as health professionals and relatives.

How we keep your records confidential

Everyone working for the NHS has a legal duty to keep information about you confidential and secure. To help us protect your confidentiality, it is important to inform us about any relevant changes that we should know about, such as change of address, telephone, change of personal circumstance.

All staff working in the practice sign a confidentiality agreement that explicitly makes clear their duties in relation to personal health information and the consequences of breaching that duty.
Access to patient records by staff other than clinical staff is regulated to ensure they are only accessed when there is a genuine need to do so, such as when identifying and printing repeat prescriptions for patients, or when typing referral letters to hospital consultants.

How your information may be used

We will share information in your health record to allow health professionals to work together more effectively to ensure you receive the best quality care. You may choose not to share your information by completing the form at the end of this leaflet.

Summary Care Record

One of the ways of sharing your health information for your care is through the Summary Care Record (SCR). The SCR is available nationally to health professionals who may care for you. It contains important information about any medicines you are taking, any allergies you suffer from, and any bad reactions to medicines that you have had. Access to this information can prevent mistakes from being made when caring for you in an emergency, or when your GP practice is closed.

You can also ask for your SCR to include additional information about you, such as your current health conditions. This is known as an Enriched SCR.

We will only add information to your SCR with your consent; please complete the form enclosed with this leaflet to let us know whether or not you would like a SCR. You can change your mind at any time – just complete another form.
Further information on the SCR can be viewed at: https://www.digital.nhs.uk/summary-care-records.

SystmOne - GP Clinical System

Another way of sharing your information for your care is through the confidential electronic record system that we use in our practice, called SystmOne. This is used widely across the NHS and care organisations to keep accurate medical records about you. These records store important information about your illnesses and the care you have received in the past. Your record may contain information from different health and social care organisations such as a hospital, a minor injuries unit, or from a community care service such as district nursing.

Organisations can only access your medical record if you give them permission. For example, you may be working or on holiday in another part of the country and need care from a hospital or a clinic. Having access to your whole medical record will improve the care they can provide you.

How does this work?

You will need to give us your preferred mobile phone number or email address, which we will record on your medical record. This means that when another organisation asks to access your record, we can send you a verification (security code) which allows you to choose whether to let that organisation view your medical record or not.

If you already use the SystmOnline patient portal, then you can select organisations to allow or prevent them from accessing your records. If you do not have a phone or email address and don't use SystmOnline, then we will be happy to record your choices about which organisations you are happy to share your whole record with. When you receive care from organisations close to your home (Dorset), you will not usually need to give a verification (security) code because we work regularly with these organisations. However, you should still be asked for your consent to share.

Further information about SystmOnline and these sharing controls, can be viewed at: https://systmonline.tpp-uk.com/2/help/help.html.

Can I ask for my information not to be shared?

Organisations using SystmOne should only access your record when they are involved in giving you care. Whenever a professional from another organisation wishes to view your record, they will always ask for your consent. If you choose not to allow them to access your record, they will not be able to see any information. However, you should be aware that this could disrupt your care.

If you are a carer and have a ***Lasting Power of Attorney for health and welfare*** then you can decline on behalf of the patient who lacks capacity. If you do not hold a ***Lasting Power of Attorney*** then you can raise your specific concerns with the patient's doctor.

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What do I need to do now?

After reading this information, note your decisions on the enclosed form and return to Reception. You can change your mind at any time, just complete another form.

Please contact reception if you have any further queries on how we use and share your information. They will arrange for a member of staff to contact you.

WEST MOORS VILLAGE SURGERY
SUMMARY CARE RECORD SHARING AND SYSTMONE RECORD SHARING

We strongly recommend that you allow other health professionals to access your medical record. The benefits to your care are immense:
Your Clinician will have a complete view of your medical history allowing accurate decisions to be made.
You will not have to explain your medical history countless times.
Your care will improve and unnecessary tests can be avoided.

Please complete the information below with your choices on sharing your data and hand to Reception:

Name: _____ **Date of birth:** _____

Signature: _____ **Date:** _____

If you are filling out this form on behalf of another person or a child, their GP will consider this request. Please ensure you fill out their details above and your details below:

Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

Sharing using Summary Care Record Please tick one option:

I agree to a Summary Care Record containing details of my medications, allergies, and any bad reactions to medication. ☐

I agree to a Summary Care Record containing details of my medications, allergies, any bad reactions to medication AND any additional information useful for my care. ☐

I do not want to have a Summary Care Record (opt out). ☐

Sharing using SystmOne GP Clinical System Please tick one option:

I agree to sharing my data on SystmOne for my direct care ☐

Please state your email address and mobile telephone number below to enable us to send you a security code when another organisation wishes to view your information on SystmOne:

Please write both clearly so the correct information is entered on the patient record.

Email address: _____

Mobile telephone number: _____

I do not agree to the sharing of my information on SystmOne for the purposes of my direct care ☐

ONLINE ACCESS TO HEALTH RECORDS REQUEST

In accordance with the UK General Data Protection Regulation (UK GDPR)

Guidance notes – please read before completing this form:

If a child aged 13 or over has 'sufficient understanding and intelligence to enable him/her to understand fully what is proposed' (known as Gillick Competence), then s/he will be competent to give consent for him/herself but may wish a parent to countersign as well.

- Patients requiring access to their own record (Sections 1, 2 and 7)
- Proxy access to health records where patient has capacity (Sections 1, 3, 5, 6 and 7)
- Proxy access to health records where patient does not have capacity (Sections 1, 4, 5, 6 and 7). All children under the age of 11 are assumed to lack capacity to consent to proxy access – refer to 10.4 in Access to Medical Records Policy
- Parents requiring access to their child's (age 11-17) record (Sections 1, 3, 5, 6 and 7)

Section 1: Patient details

Surname		**Former name**	
Forename		**Title**	
Date of birth		**Address:**	
Email address			
Telephone number		**Postcode:**	
NHS number (if known)		**Hospital number (if known)**	

Section 2: Record requested

I wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

I have read and understood the information leaflet in the following link: pat-guid-need-to-know.pdf (england.nhs.uk)	☐
I understand that I will automatically see any new information (prospective records) that is added to my healthcare record.	☐
I will be responsible for the security of the information that I see or download	☐
If I choose to share my information with anyone else, this is at my own risk	☐
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	☐

Patient signature		**Date**	

Section 3: Consent to proxy access to GP Online Services (if patient has capacity)

- I…… (name of patient), give permission to my GP practice to give the following person/people …… proxy access to the online services as indicated below in Section 5
- I reserve the right to reverse any decision I make in granting proxy access at any time
- I understand the risks of allowing someone else to have access to my health records
- I have read and understand the information leaflet provided by the organisation

Patient signature		**Date**	

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)
Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request or is incapable of understanding the request (delete as appropriate)	☐

Section 4: Consent to proxy access to GP Online Services (if patient does not have capacity)

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper).

Reason for access:

The patient is under age 11 and I/we have parental responsibility/guardianship responsibility	☐
I/We have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	☐
I am/We are acting *in loco parentis* and the patient is incapable of understanding the request	☐
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	☐
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	☐

I/We have a claim arising from the person's death (please state details below)	☐

Section 5: Proxy access online services available

I/We wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

Section 6: Proxy declaration

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

I/We have read and understood the information leaflet in the following link: pat-guid-need-to-know.pdf (england.nhs.uk) and agree that I/we will treat the patient information as confidential	☐
I/We will be responsible for the security of the information that I/we see or download	☐
I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	☐

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the Data Protection Act 2018.

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Applicant signature		**Date**	

Section 7: Proof of identity

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.

For children a copy of the birth certificate or passport must be provided.

Please speak to reception if you are unable to provide this.

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- Signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

For office use only: **Identification verification must be verified through two forms of ID**

- One of which must contain a photo e.g., passport, photo driving licence or bank statement Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the management team or a partner may be used

Request received		Request refused	
Reviewed by HCP		Request completed	
Comments			

	ID verification to be completed by receptionist:			
Identification of	☐ Child under age 13 ☐Parent/Guardian	☐ Child aged 13-17 ☐Parent/Guardian	☐ Patient	☐ Applicant - Proxy
Does the applicant [for proxy access] also have SystmOnline access or has submitted form with this? If not, and they are a patient at WMVS they will need to submit the SystmOnline form.				
Identity verified by:		Date:		
Identity method	☐ Address ID - proof of residence – Type …….. ☐ Photo ID - Type …….. ☐ Applicant – Proxy Address ID – Type ……..…….. ☐ Applicant – Proxy Photo ID - Type …….. ☐ Birth Certificate or Passport of child – photocopy and attach ……..…			

☐ Vouching – by whom ……

☐ Vouching with information in record – by whom ……

Proxy access authorised by				
Proxy access coded in notes	☐ Yes	NHS No:		
Date account created		Date password sent		
Level of access enabled	☐ All	☐Prospective	☐ Retrospective	☐ Limited parts
Notes for proxy access *(If any request is refused, discuss with the organisation's DPO before informing patient/applicant)*				

West Moors Village Surgery

Patient Representative Group

We're setting up a patient reference group to give us feedback on the range and quality of our services and to tell us where we can improve.

Our aim is to reach a wide range of patients, so we get views from across our population. To make it as easy as possible for you, it will be a virtual group. This means most of the communication will be through email and completing online surveys. However, we'll make sure those without internet access can also take part.

What will be involved?

The main role of the group is to give feedback through a survey. It asks patients a series of simple questions about how we are doing.

We want to pose the right questions, so the group will be asked to tell us what questions we should be asking. We will then publish the survey results along with our proposal to improve the areas it highlights as in need of change. You will have the chance to let us know if you agree with our plans. At the end of the year we will publish the results of our achievements.

What will I have to do?

If you are interested in helping us to improve, please ask for more information at reception.

Thank you in advance for your help.

West Moors Village Surgery

West Moors Village Surgery
Patient Representative Group

Frequently asked questions:

Q. Why are you asking people for their contact details?
A. We want to talk to people about the surgery and how well we are doing to identify areas of improvement

Q. Will my doctor see this information?
A. No. It is purely to contact patients to ask them questions about the surgery and how well we are doing. Your doctor will only see the overall results.

Q. Will the questions you ask me be medical or personal?
A. General questions about the practice, how we are providing services and what we can do to improve them.

Q. Who else will be able to access my contact details?
A. No one beyond this practice.

Q. How often will you contact me?
A. Not very often, a few times a year.

Q. What is a patient representative group?
A. It is a group of volunteer patients who are involved in shaping the services to patients.

Q. Do I have to take part in the group?
A. No, but if you change your mind, please let us know.

Q. What if I no longer wish to be on the contact list or I leave the surgery?
A. We ask you to let us know if you do not wish to receive further messages.

Q. Who do I contact if I have further questions?
A. Please contact reception or email us at wm.gp@nhs.net and someone will contact you with more information.

Your information

If you are happy to be part of the patient representative group please complete the form below and return it to the practice:

Name: _____

Date of Birth:_____

Email Address (if applicable) _____

Which of the following areas should we focus on? Please tick all that apply:

	Getting an appointment		Time keeping
	Clinical care		Patient information
	Telephone answering and access		Opening times
	Waiting room facilities		Parking
	Customer service		

Other - please specify:

Thank you for your feedback.

Please note that no medical information or questions will be responded to.
(The information you supply us will be used lawfully, in accordance with The Data Protection Act, 1998. The Data Protection Act gives you the right to know what information is being held about you and sets out rules to make sure this information is handled properly.)