

WELCOME

Thank you for asking for our registration pack to become a patient at Rock Healthcare.

Please complete all the forms enclosed and return to one of the Rock Healthcare receptionist available at Moorgate Primary Care Centre or Radcliffe Primary Care Centre along with 2 forms of identification. Your identification needs to include a photographic I.D. such as a passport or driving license and also proof of your address such as a bank statement or utility bill.

You will be invited for a 'New Patient Health Check' with a member of our Nursing Team. This is a routine medical check. It is important that you take up this offer for your benefit, particularly if you do not attend the doctors very often. The check gives us and you some important information about your health and should only take 20 minutes.

Rock Healthcare is open 8am – 6.30pm Monday to Friday. All patients of Rock Healthcare can access appointments at both our Bury and Radcliffe sites. We believe this is how healthcare should be, accessible and convenient for our patients.

Should you have any difficulty in completing the forms or require any further information then please do not hesitate to contact a member of the team on 0161 447 9820. Alternatively, please visit our website at www.rockhealthcare.co.uk.

Many Thanks

The Rock Healthcare Team

Patient's details

Please complete in BLOCK CAPITALS and tick as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of birth				First names
NHS No.				Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female				Town and country of birth
Home address				
Postcode				
Telephone number				

Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous GP practice while at that address
	Address of previous GP practice

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving	Date you first came to live in UK
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Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: Regular Reservist Veteran Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting: _____

Postcode _____

Service or Personnel number: _____ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

I live more than 1.6km in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient Signature on behalf of patient

Date _____ / _____ / _____

**Not all doctors are authorised to dispense medicines*

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: British Irish Irish Traveller Traveller Gypsy/Romany Polish
 Any other white background (please write in): _____

Mixed: White and Black Caribbean White and Black African White and Asian
 Any other Mixed background (please write in): _____

Asian or Asian British: Indian Pakistani Bangladeshi
 Any other Asian background (please write in): _____

Black or Black British: Caribbean African Somali Nigerian
 Any other Black background (please write in): _____

Other ethnic group: Chinese Filipino
 Any other ethnic group (please write in): _____

Not stated:
 Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for GMS Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

 I have accepted this patient for general medical services on behalf of the practice

 I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name

Date

____/____/____

Practice Stamp

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a) I understand that I may need to pay for NHS treatment outside of the GP practice
- b) I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
- c) I do not know my chargeable status


I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in an EU country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
 <p><i>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</i></p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with Business Service Authority for the purpose of recovering your NHS costs from your home country.

ROCK HEALTHCARE

NEW PATIENT HEALTH QUESTIONNAIRE

PATIENT DETAILS – you must complete this section

Title		D.O.B	
Surname		Occupation	
First Names		Email Address	
Home Address		Contact Number Mobile: Home: Work:	
Postcode		Previous Surname	

Proof of Identity Including the address of the patient – you must complete this section

You must provide either a Birth Certificate or Photo ID and also proof of your address using an official document

Birth Certificate	Driving Licence	Passport	Other
Utility Bill	Solicitors Letter	Offer of Tenancy	Allowance Book

What is your first language	
Do you need an interpreter Yes/No	
Name and Address of your Previous GP	

Demographic information – you must complete this section

White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other (please specify)
Black	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other (please specify)
Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese <input type="checkbox"/> Other (please specify)
Mixed	<input type="checkbox"/> White and Black Caribbean	<input type="checkbox"/> White and Black African	

	<input type="checkbox"/> White and Asian	<input type="checkbox"/> Other (please specify)
Are you an asylum Seeker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sexual Orientation	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Gay/ Lesbian	<input type="checkbox"/> Heterosexual / Straight
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Are you a Military Veteran or have you ever served in the armed forces in the past	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Are you registered Disabled? (if yes, please give details)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any Allergies to any Medication? If yes, please give details)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Current Medication being prescribed by your previous GP at the time of registration	<u>Please bring along with your completed registration, a medication list that is usually attached to your repeat prescription form</u>
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Other Information

Do you have a carer? If yes please provide the name and address of your carer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a carer? If yes, please provide the name and address of the person you care for. This includes anyone who cares paid or unpaid for a friend or family member, who due to illness, disability, a mental health problem, or an addiction, cannot cope without your support	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever had a cervical smear If YES, Please state WHEN and WHERE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Smoking – you must complete this section

Do you Smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If No, have you ever smoked	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you Currently smoke, how many cigarettes do you smoke in a day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like advice on giving up smoking, please tick the relevant box, if yes then you will need to contact the Lifestyle team on 0161 253 7554 who will be able to offer the cessation advice for you	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Alcohol – you must complete this section

Do you Drink Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
FAST	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	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 from you because of your drinking?	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	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

NOK Details for all Patients – you must complete this section

<u>Please provide details of your Next of Kin including name, address and telephone number</u>	
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Are you eligible for the Flu Vaccine to be completed

Are you Aged 65yrs or over or on a chronic disease Register, if you are unsure please ask a member of the team who can check your eligibility

Have you ever had the Seasonal Influenza Vaccination? (FLU) Please enter the date of your last influenza Vaccination and where this was given	
Have you ever had the Pneumococcal vaccination? Please enter the date of your last Pneumococcal Vaccine and where it was given	

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you.

Patient Participation Group

If you are interested in joining our Patient Participation Group (PPG) then Please tick the correct box and someone from the surgery will get in touch with you at some point in the future regarding this

Yes

No



Information for new patients: about your Summary Care Record

Dear patient,

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 who 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.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.
- **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, 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:

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
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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.	XaXj6