

**FIRST HEALTH UK LIMITED  
St John's Surgery**

**Welcome to St John's Surgery**

**New patient questionnaire guidelines:**

**Please complete all areas on the form where possible.**

**Appointments:**

Please ensure that this registration is completed 48 hours before an appointment is required.

**Identification:**

Passport, Photo Driving Licence or Birth Certificate will be required before registration can be completed.

Your NHS number can be obtained from your previous GP surgery.

**Medication:**

If you are on any repeat medication please enclose a list such as your repeat slip so this can be processed ready for your next request and clearly mark if you require any items at the time – please allow 7 days for your order after registering.

**Next of Kin:**

Please provide name, address and telephone number and relationship details.

**Family History and Chronic Illnesses/Operations:**

Please provide any immediate family history and any current or past history for yourself.

**New Patient Appointment:**

We offer a New Patient appointment with one of our Nurses – which should be booked when handing in your completed registration forms.

**Thank you for your time, if you have any queries with regards to these forms please do not hesitate to ask a member of our reception team.**

**TERRINGTON ST JOHN SURGERY**

**First Health UK Limited**

*NEW PATIENT QUESTIONNAIRE*

Office use  
only

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_ GENDER: M/F

ADDRESS: \_\_\_\_\_ HOME TELEPHONE NUMBER: \_\_\_\_\_

\_\_\_\_\_ MOBILE NUMBER: \_\_\_\_\_

\_\_\_\_\_ PREFERRED TELEPHONE

\_\_\_\_\_ NUMBER: \_\_\_\_\_

CONSENT FOR SMS: Yes  No

EMAIL ADDRESS: \_\_\_\_\_

YOU WILL BE AUTOMATICALLY REGISTERED FOR ONLINE SERVICES.

OCCUPATION: \_\_\_\_\_

NEXT OF KIN NAME, RELATIONSHIP AND CONTACT DETAILS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

ETHNICITY: \_\_\_\_\_ WHERE WERE YOU BORN? \_\_\_\_\_

WHEN DID YOU ARRIVE IN THE UK? \_\_\_\_\_

DO YOU REQUIRE AN INTERPRETER? Yes  Language: \_\_\_\_\_

No  First Language: \_\_\_\_\_

RELIGION: \_\_\_\_\_

ARE YOU A CARER?: Y/N IF SO WHO FOR? \_\_\_\_\_

ARE YOU CARED FOR? Y/N

DO YOU HAVE ANY CLOSE FAMILY HISTORY OF THE FOLLOWING? IF SO, PLEASE STATE WHICH FAMILY MEMBER:

Heart Disease?  Stroke?  Hypertension?  Diabetes?  Asthma?  Breast Cancer?  Epilepsy?   
Who..... Who..... Who..... Who..... Who..... Who..... Who.....

IF YOU HAVE ANY HISTORY OF SERIOUS OR CHRONIC ILLNESS OR OPERATIONS PLEASE GIVE DETAILS OF THEM HERE:

IF NONE TICK HERE

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\_\_\_\_\_ / \_\_\_\_\_

IF YOU ARE CURRENTLY ON ANY MEDICATION, PLEASE ATTACH YOUR LAST REPEAT PRESCRIPTION SLIP  
(Please book a new patient medical if you require medication, failure to do so may result in you being without your medication for a period of time)

IF NONE TICK HERE

IF YOU HAVE ANY MOBILITY, SIGHT AND HEARING DIFFICULTIES PLEASE GIVE DETAILS HERE

IF NONE TICK HERE

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DO YOU CONSIDER YOURSELF TO HAVE ANY INFORMATION OR COMMUNICATIONAL NEEDS? E.G. SENSORY LOSS OR IMPAIRMENT. PLEASE GIVE DETAILS BELOW.

IF NONE TICK HERE

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IN ORDER TO ENSURE WE MEET YOUR NEEDS PLEASE DETAIL BELOW WHAT WE CAN DO TO HELP.

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IF YOU HAVE ANY ALLERGIES, PLEASE LIST THEM HERE

IF NONE TICK HERE

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IF KNOWN, WHEN WAS YOUR LAST TETANUS INJECTION?

IF NOT KNOWN TICK HERE

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HAVE YOU EVER SMOKED? Yes

No

If yes how many a day? \_\_\_\_\_

Are you interested in quitting?  *NB. You can speak to one of our trained nurses for more information.*

No  Ex-Smoker  When did you quit? \_\_\_\_\_

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DO YOU DRINK ALCOHOL? Yes  No   
 Teetotaler  Occasional/Light Drinker  Moderate  Heavy

IF YES PLEASE COMPLETE THE FOLLOWING AS PART OF A DEPARTMENT OF HEALTH REQUEST:

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
Q1. How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>Only consider questions 2, 3 and 4 if the response to Q1 is Monthly or less</b>						
Q2. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q3. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q4. Has a relative, friend, Doctor or Health Worker been concerned about your drinking or advised / suggested you to cut down?	No		Yes, but not in the last year		Yes, on more than one occasion	

WHAT IS YOUR HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ARE YOU AN EX SERVICE MEMBER? IF SO, PLEASE TICK BELOW.

ARMY  ROYAL NAVY  ROYAL AIR FORCE  OTHER

**WOMEN:** PLEASE GIVE DATES AND DETAILS OF ANY PREGNANCIES:

**WOMEN:** WHEN WAS YOUR LAST SMEAR? WHAT WAS THE RESULT?

**WOMEN:** WHAT METHOD OF CONTRACEPTION DO YOU USE?

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.**

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\_\_\_\_\_ / \_\_\_\_\_



**PATIENT THIRD PARTY CONSENT FORM**

**PATIENT'S NAME:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**NAME OF PERSON TO BE  
CONSENTED:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**THE CONSENT OF THE PATIENT IS REQUIRED. PLEASE OBTAIN THE  
PATIENTS'S SIGNED CONSENT BELOW.**

I fully consent to my Doctor releasing information to, and discussing my care and  
medical records with the person named above.

If there are any conditions and restrictions to the consent, please list below;

.....  
.....

This authority if for an indefinite period / for a limited period only *(delete as appropriate)*  
Where a limited period applies, this authority is valid until.....

Signed..... *(patient only)*

Date.....

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## NHS Summary Care Record with additional information

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If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

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 SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

You can choose to have additional information included in your SCR, which can enhance the care you receive. This information 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
- Who should be contacted for more information about you

### What to do next

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form, for return to the relevant GP surgery.

Name of Patient: .....

Date of Birth: ..... Patient's Postcode: .....

Surgery Name: **St John's Surgery** Surgery Location (Town): **Terrington St John**

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.....

Capacity

Please circle one

Parent	Guardian	Lasting Power of attorney for health and welfare
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If you require any more information, please visit [www.hscic.gov.uk/scr/patient](http://www.hscic.gov.uk/scr/patient) phone HSCIC on

0300 303 5678 or speak to your GP Practice.

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## What to expect as a patient at St Johns Surgery

- For **routine** appointments and general enquiries please call after 10.30am
- For **urgent** problems requiring an appointment on the same day please call at 8am
- We allocate a 10 minute appointment per problem – please request a double appointment at time of booking if there are 2 problems to discuss and so on
- Please be aware that reception will ask for your symptoms in order to book you an appointment with the appropriate clinician to deal with it. This is at the request of our Clinical Lead.
- The surgery operates a triage system which means you may be offered a telephone consultation rather than a face to face appointment
- We have three nurse prescribers who are able to assist patients with acute illnesses – a GP appointment is not always needed.
- If you are unable to attend an appointment, please contact us to either cancel or reschedule at your earliest convenience
- If a clinician asks you to make a follow up appointment, please book the appointment with reception when leaving the surgery.
- For simple illnesses such as coughs, colds etc, please seek advice from your local Pharmacist
- If medical advice is required outside of our opening times please call 111
- The surgery does not issue antibiotics on demand. They will only be prescribed in line with national guidance
- We will prescribe non-generic drugs in line with Norfolk & Waveney prescribing Guidelines to keep down the cost to the NHS
- Please be advised we do not deal with dental problems. Please contact your dentist, or 111 if you are not registered with one
- We do not accept medication requests over the telephone
- Medication requests must be made in writing
- Please allow 48 working hours for medication requests to be processed
- We do not offer a Smoking Cessation service – please contact your local pharmacy or call SmokeFree on 0300 123 1044
- We do not offer Travel Vaccinations – please contact your local Travel Clinic for advice
- Please ensure your contact details are kept up to date and provide us with a mobile number to allow the use of the SMS text messaging service
- We will not disclose any information about you to anyone, including family members. This includes (but not limited to) booked appointments, prescriptions and results
- If you wish us to discuss information about you with your partner or a family member, you must give us your consent in writing. Reception will provide the necessary 3<sup>rd</sup> Party Consent form for you to complete
- We aim to provide you with the best care. If you have concerns about any aspect of your care please contact the Practice Manager who will treat your concern in confidence