**Cavendish Medical Practice**

**Registration Pack**

**Opening Hours:**

Monday to Friday

8:00am – 6:30pm

**Extended Opening Hours on Wednesday:**

6.30pm - 8.00pm

**Daytime Contact Number:**

0121 203 2050

**Outside Surgery Hours:**

0121 7662100

NHS 111

**Emergency Service:**

999

**Doctors:**

Dr T Cheema

Dr K Cheema

**PLEASE KEEP THIS PAGE FOR YOUR INFORMATION**

www.cavendishmedicalpractice.co.uk

New Patient Registration Form – Cavendish Medical Practice 1 of 5

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

**Patient Details**

|  |  |
| --- | --- |
| Title | Date of Birth |
| Surname | First Name(s) |
| Previous Surname(s) | Occupation |
| Address | Email |
| City | Telephone no. |
| Post Code | Mobile no. |

From time to time we may need to contact you (Please see privacy notice). Please tick below to indicate how you prefer to be contacted.

|  |  |  |
| --- | --- | --- |
| [ ]  Phone | [ ]  Email | [ ]  Post |

If you hare happy to receive health promotion and surgery updates, please tick here [ ]

If you do not wish to be contacted at all, please tick here and discuss with a member of staff [ ]

**Previous GP**

|  |
| --- |
| Name |
| Name of Practice |
| Address |
| City |
| Post Code |

New Patient Registration Form – Cavendish Medical Practice 2 of 5

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

**Next of Kin**

|  |  |
| --- | --- |
| Name | Relationship |
| Address |  |
| City |  |
| Post Code | Telephone no. |
| Are you happy for the surgery to contact this person in an emergency?  |
| Does this person have legal powerof attorney?  |
| If NoK for a relative is in a care home, is DoLs in place?  |

**Children**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Child(ren) | Date of Birth | Current Nursery/School | Disability? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Are you a carer for any other children?  | Do you have parentalresponsibility?  |
| Any history of Female GenitalMutilation (FGM)/cutting?  | Any previous involvement withChildren’s Social Care?  |

New Patient Registration Form – Cavendish Medical Practice 3 of 5

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

**Ethnicity**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **White** |  | British |  | **Black or Black British** |  | Caribbean |
|  | Irish |  | African |
|  | Other (please specify) |  | Other (please specify) |
|  |  |  |
| **Asian or Asian British** |  | Indian  |  | **Mixed** |  | White & Black Caribbean |
|  | Pakistani |  | White & Black African |
|  | Bangladeshi  |  | White & Asian |
|  | Chinese |  | Other (please specify) |
|  | Other (please specify) |  |
|  |  |  |  |
| **Eastern European** |  | Polish  |  |  |  |
|  | Romanian |  |  |  |
|  | Czech Republic |  |  |  |
|  | Other (please specify) |  |  |  |

**Language**

|  |  |
| --- | --- |
| What is your first language? | Do you requirean interpreter?  |
| Are you a refugee/asylumseeker?  | Are you new to the UK?  |

**Proof of Identity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [x]  Passport | [ ]  Driving License | [ ]  Utility Bill | [ ]  Birth Certificate | [ ]  Other |

Do you wish to sign up for access to your digital health record? [x]

New Patient Registration Form – Cavendish Medical Practice 4 of 5

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

**Disabilities**

|  |
| --- |
| Are you a registered disable? If so, please give details |

**Medical Information**

Please tick the box next to the medical condition that you have

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy |  | Blindness |  |
| High Blood Pressure |  | Glaucoma |  |
| Heart attack |  | Diabetes |  |
| Stroke |  | Asthma |  |
| Cancer |  | Depression |  |
| Eczema |  | Other (please specify) |  |

|  |  |
| --- | --- |
| Have you had a fluvaccination?  | Have you had a pneumoniavaccination?  |
| Have you ever had a cervical smear? If so, when was the last one?   |
| Do you smoke? If so, how many per day?  | Would you like advice ongiving up smoking?  |
| How much alcohol do youdrink in a week? | Would you like support toreduce your alcohol intake?  |

New Patient Registration Form – Cavendish Medical Practice 5 of 5

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Please list any current medication with their doses

|  |  |  |
| --- | --- | --- |
| Medication | Reason for taking | Dose |
|  |  |  |

|  |  |
| --- | --- |
| Are you allergic to any medications?   | If so, please give details |
| Do you have anyother allergies? | If so, please give details |

**Safeguarding**

|  |
| --- |
| Have you ever experienced domestic abuse?   |
| Are you currently experiencingdomestic abuse?   |
| Do you require anysupport?   |

A Patient Participation Group (PPG) is a group of volunteer patients, the practice manager and one or more of the GPs from the practice. They meet on a regular basis to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice.

Would you be interested in joining our PPG? [ ]

(If you ticked the box, please fill out the membership form)

|  |
| --- |
| Name (PRINT) |
| Signature | Date |

**Patient Participation Group**

A Patient Participation Group (PPG) is a group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. Meetings are held once every quarter at the practice, either face to face or remotely. If you are available and interested in joining us then please fill in the member sign up form below.

Member Sign-up

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return completed forms to the Cavendish Medical Practice reception.**



Website: [www.MidlandsYourCareConnected.nhs.uk](http://www.midlandsyourcareconnected.nhs.uk/) Email: infoMidlandsYourCareConnected@nhs.net Tel: 0333 150 3388 (Leave a voice message)

Your medical history could save your life

Your GP Practice is part of Your Care Connected (YCC), a potentially lifesaving NHS record sharing service, implemented across Birmingham, Sandwell and Solihull to provide better, safer care. If you need to attend a local hospital, YCC makes it possible for registered healthcare professionals caring for you to securely access important medical information from your GP record to provide you with better, safer care.

Your Care Connected will only be used to improve the care you receive when you visit one of the local NHS organisations across Birmingham, Sandwell and Solihull as listed on our website:

[www.MidlandsYourCareConnected.nhs.uk](http://www.midlandsyourcareconnected.nhs.uk/)

Your data will not be: extracted, stored elsewhere, used for research or marketing or sold to any other organisations. If you opt-out of Your Care Connected, it will also automatically stop your record being shared for any other local record sharing projects (for example, GP practice to practice sharing for extended opening hours and seven day access).

Your information, your choice

If you are happy to take part:

You do not need to do anything if you are happy to have your information accessed using Your Care Connected. If you visit one of the organisations listed on our website, those treating you will ask for your permission to view your record to help improve the care you receive.

If you do not want your information shared:

You will need to ‘opt-out’. This will mean only your GP practice will be able to access your record. To ‘opt-out’, please complete the form below and give this back to your practice. Your practice will then process your request to turnoffrecordsharing.

Opt out form: Only complete if you do not want your information shared

Please complete this form in BLOCK CAPITALS if you do not want your information to be shared using Your Care Connected for the purpose of improving your direct care when visiting one of the participating NHS organisations. If you wish to opt out on behalf of a child or vulnerable adult, you must request this from their registered GP practice by using this form. However they may decline your request if they believe it is not in the best interests of the child or vulnerable adult in question.

Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHSNo (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(DD/MM/YYYY)

I do not want my information to be shared via Your Care Connected. I understand that this may mean important information will not be available to those treating me when making decisions about my treatment in potentially urgent and life-threatening situations. I understand that by opting out of Your Care Connected I will also opt out of any other local sharing initiatives by default. I also understand that if I change my mind I can only opt back in by visiting my GP Practice.

|  |
| --- |
| Signed:                                                                             Date:                                               |

Please complete and return to your GP practice.

|  |
| --- |
| FOR NHS USE ONLYDate: Actioned by: |

**Consent for Online Access to Medical Records**

**Patients Form**

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up the and operate the service.

The following form will take you through the things you need to think about. By signing the form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way. At the moment you can view allergies and immunisations. In the future more access may become available but you will not need to sign another access form but we may need to activate your records accordingly if you request to do so if more options becomes available.

**Declaration (please circle choice as appropriate):**

|  |  |
| --- | --- |
| 1. I agree to my GP practice giving me access to my record online.
 | YES / NO |
| 1. I have read and understood the information about access to GP medical records.
 | YES / NO |
| 1. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.
 | YES / NO |
| 1. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.
 | YES / NO |
| 1. I agree that it is my responsibility to keep secure, my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.
 | YES / NO |
| 1. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.
 | YES / NO |
| 1. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*
 | YES / NO |

**Other considerations**

|  |
| --- |
| The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.  |
| 1. If I notice any inaccuracies with my record, I will inform a senior member of staff or the practice manager as soon as possible of any errors or omissions.
 | YES/NO |
| 1. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.
 | YES / NO |
| 1. I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.
 | YES / NO |

To be signed at reception by patient………………………………..……………..….

Date…………………………

***Please retain this copy of this form for your information.
Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to a senior member of staff or the practice manager.***

*For practice use only:*

*ID checked documents……………………………….Initials…………….Date:..……..…….*

*GP authorised:……………………………………………………………………Date:………………

 Medical Records Activated:……………………………………………….………………Date:……………...*

**Accessible Information Needs Questionnaire**

At *Cavendish Medical Practice* we want to make sure that we give you information in a way that is clear to you, and to have on record any communication needs you might have.

The NHS Accessible Information Standard aims to ensure those patients and their carers who have a disability, impairment or sensory loss can receive access and understand information and that they receive professional communication support if they need it.

This questionnaire has been designed to give you the opportunity to inform us if you have any difficultly in reading or understanding the information that we send you and record your preferred way of communicating with the surgery and its staff.

|  |  |  |
| --- | --- | --- |
|  | **Question** | **Please tick** |
| 1. | Do you have any communication or information needs which are related to a disability, impairment, sensory loss or learning disability? | Yes |  |
| No |  |
| 2. | When we write to you or contact you, do you need us to communicate in a particular way? | Yes |  |
| No |  |

If your answer is **no** to both questions one and two, **please sign and date** the form and return to the reception staff. If yes, please complete the rest of this form.

|  |  |  |
| --- | --- | --- |
|  | **Question** | **Answer** |
| 3. | What disability, impairment, sensory loss do you have that affects your communication or information needs? |  |

Please choose your preferred method for us to contact you with information, such as a letter to invite you in for a flu vaccination:

| **Method or Format** | **Please tick or provide details**  |
| --- | --- |
| **Text** (please confirm the number) |  |
| **Email** (please confirm your email address) |  |
| **Braille** |  |
| **Easy read document** |  |
| **Other** (please tell us what this is) |  |

|  |  |
| --- | --- |
| **Question** | **Please tick** |
| When you come into surgery for an appointment do you need a British Sign Language interpreter? (13O85) | Yes |  |
| No |  |
| Can we share this information with other health and social care providers (for example if you needed to attend an outpatient clinic at hospital)? | Yes |  |
| No |  |

Thank you for completing this form, please return it to the reception. We will update your patient records so that every time you book an appointment or we need to contact you we will do so using your preferred method.

You can find more information about the NHS Accessible Information Standard on NHS England’s website <https://www.england.nhs.uk/ourwork/patients/accessibleinfo/>

|  |  |
| --- | --- |
| Signature | Date |