

CONSENT

Patient records are held on the computer as well as paper. GPs are responsible for the confidentiality of these records. On occasion, we share information from the patient records with the Health Authority, the local Primary Care Group/Trust, hospitals and other NHS/partner organisations in the interest of patient care.

I agree to my medical records being held under the above terms and certify that the information I have provided is correct to the best of my current knowledge.

Signature..... Date.....

RIGHTS AND RESPONSIBILITIES FOR PATIENTS AND THE PRACTICE

We believe that the practice and patients both have rights and responsibilities to ensure a friendly, courteous and efficient service provided under a safe environment. Below are some responsibilities that patients and the practice should always follow.

Patients

- You have the right to a full explanation of your illness and any tests, investigations or consultations relating to that illness.
- If you require a referral to a specialist you will be offered choice, in accordance with the NHS 'Choice and Booking' agenda.
- You should treat the doctor, nurse and other staff members and patients with courtesy and respect at all times.
- As this is a busy practice, please be patient if the doctor/nurse is running late.
- All non-NHS services will incur charges depending on the service requested, please confirm the agreed fee with staff before proceeding with your request. Any private report etc. is provided on the basis of your medical conditions and fees are charged in respect of time spent preparing such reports, therefore fees are non-refundable.
- Please note that first seven days of any sickness a self-certificate (SC2) is sufficient. However, if requested a private certificate may be issued and appropriate fee charged.
- 48 hours notice is required for all repeat prescriptions. Requests for repeat medication are not accepted over the phone. Please use a SAE or attend the surgery in person .All repeat medication should be ordered in advance and not when you have run out. Repeat medication will only be issued when due, in accordance with the dose indicated by your doctor.
- Please ensure a single appointment is for one person and one problem only. If you have more than one medical problem please inform the receptionist when booking your appointment.

Practice

- Everyone attending the practice is to be treated with respect and courtesy at all times, irrespective of his/her ethnic origin, religious beliefs, personal attributes, or the nature of health problem.
- We will maintain your right to privacy and confidentiality and will not discuss your illness with other staff members on an unprofessional basis.

We maintain the right to remove patients from our list who display unacceptable behaviour or violence towards staff or other patients.

Please sign below if you accept these terms and conditions.

Patient's signature..... Date.....

INITIAL REGISTRATION ENQUIRY

PLEASE USE CAPITAL LETTERS

PLEASE NOTE BY COMPLETING THIS FORM YOU WILL NOT AUTOMATICALLY BE REGISTERED. YOUR REGISTRATION WILL ONLY BE COMPLETE WHEN YOU HAVE FILLED FULL REGISTRATION FORMS.

CONTACT AND PERSONAL DETAILS

FIRST NAME: _____ SURNAME: _____
 DOB: _____ SEX: M F (PLEASE CIRCLE)
 ADDRESS: _____
 OCCUPATION: _____ MARITAL STATUS: _____
 HOME TEL: _____ WORK TEL: _____
 MOBILE TEL: _____ (PLEASE CIRCLE PREFERRED TYPE OF CONTACT)
 COUNTRY OF ORIGIN: _____
 MAIN LANGUAGE SPOKEN: _____
 NEXT OF KIN: _____ RELATIONSHIP: _____
 CONTACT NUMBER: _____

TB SCREENING

Hammersmith and Fulham PCT now requires practices to offer TB screening to all patients who have arrived in to the UK within the last 5 years from a country recognised as having high prevalence of TB (see list attached). To ensure all patients are offered TB screening appropriately kindly answer the following questions:

Where were you born? : _____ If born outside the UK when did you arrive in to the UK? : _____

Which country have you arrived from? :

If you require a referral for TB screening you will be advised accordingly and you will be contacted directly by the TB nursing team to arrange a suitable and convenient appointment.

If you require any further information regarding the PCT's TB Screening Program please ask a member of the practice team.

FOR SURGERY USE ONLY

Please indicate if following have been completed by ticking next to each indicator

Smoking & Alcohol		Main Language		Carer Status & Advice (if appropriate)	
Ethnicity		TB Screening Question		Information checked by:	

PLEASE COMPLETE ALL THE QUESTIONS ON THIS FORM. IF YOU NEED ASSISTANCE WITH THIS FORM, PLEASE ASK A MEMBER OF STAFF.

ETHNICITY

PLEASE INDICATE YOUR ETHNIC ORIGIN BY WRITING THE ALPHABETIC LETTER THAT APPEARS BESIDE YOUR ETHNIC GROUP IN THE BLANK SPACE PROVIDED.

Ethnic Group _____

A	WHITE	BRITISH
B	WHITE	IRISH
C	WHITE	ANY OTHER WHITE BACKGROUND
D	MIXED	WHITE AND BLACK CARIBBEAN
E	MIXED	WHITE AND BLACK AFRICAN
F	MIXED	WHITE AND ASIAN
G	MIXED	ANY OTHER MIXED BACKGROUND
H	ASIAN OR ASIAN BRITISH	INDIAN
I	ASIAN OR ASIAN BRITISH	PAKISTANI
J	ASIAN OR ASIAN BRITISH	BANGLADESHI
K	ASIAN OR ASIAN BRITISH	ANY OTHER ASIAN BACKGROUND
L	BLACK OR BLACK BRITISH	CARIBBEAN
M	BLACK OR BLACK BRITISH	AFRICAN
N	BLACK OR BLACK BRITISH	ANY OTHER BLACK BACKGROUND
O	OTHER ETHNIC GROUPS	CHINESE
P	OTHER ETHNIC GROUPS	ANY OTHER ETHNIC GROUP
Q	NOT STATED	

LIFESTYLE

What is your height?..... What is your weight?..... if unsure please leave blank

Do you smoke: Yes / No if yes, how many a day ()

Do you drink alcohol: Yes / No if yes, Average amount of units consumed per week ()
(e.g. 1 unit = 1 glass of wine or 1 unit = half pint of beer, or 1 unit = 1 measure of spirit)

Describe your weekly exercise: Inactive / Moderate / Vigorous / Gentle

Type of exercise e.g. Swimming, running, gymnasium etc.
.....

Describe your diet / eating habits e.g. vegetarian, low fat etc.....

Are you allergic to any drug or medicine? Yes / No Please State
.....

IF ANY OF THE FOLLOWING SECTIONS DO NOT APPLY TO YOU PLEASE PUT A LINE THROUGH THE RESPECTIVE SECTION

Carers The Hammersmith and Fulham PCT recognises that informal carers provide an invaluable service and in partnership with the LBHF, are keen to ensure that carers are provided with all available support and information to help them; to this effect please provide the following details:

Are you a carer? Yes / No

Is someone a carer for you? Yes/No – If yes please provide details of your carer: Carers full name:
Contact Number:

Is she/he registered as a carer? Yes/ No

Hammersmith & Fulham Carers' Centre: 020 8563 8014/8019

For information and Assessment Service: 020 8753 5456

MEDICAL HISTORY

PLEASE GIVE DETAILS OF ANY SIGNIFICANT PAST MEDICAL HISTORY; PLEASE INCLUDE ANY PREVIOUS MAJOR ILLNESSES, MEDICAL PROBLEMS AND OPERATIONS WITH CORRECT DATES.

History	Outcome	Date
Example: high blood pressure	Currently on medication	Since 2001
Example: Major Heart Operation	Fully recovered	04/2006

IF YOU ARE TAKING ANY REGULAR MEDICATION, PLEASE STATE NAME AND DOSAGE.

Name of Medication	Dosage
Example: Paracetamol 500mg	4 times a day

HAVE YOU HAD ANY VACCINATIONS WITHIN THE PAST 10 YEARS? PLEASE STATE (INCLUDING CHILDHOOD IMMUNISATIONS) WITH DATES.

For children under 7, please bring red book or a list of all child vaccinations given.

Vaccination	Date	Where	Date
Example: Hepatitis A	01/01/2009	Last GP	01/01/2006

Family Medical History

Please state any significant family medical history e.g. heart disease, and state the family member.

Illness	Family Member	Status
Example: Heart Disease	Mother	Deceased

FEMALE PATIENTS ONLY

Last cervical smear date:
Taken where:

Results:
recall date: