Welcome to

Yorkshire Street Medical Centre

This pack consists of all the documents required for registering as a patient at our Surgery.

Please complete the purple registration form and questionnaire and then return to the receptionist. You will be asked to make an appointment for a new patient health check. If you fail to attend, you will not be registered at the Practice.

Please read through the patient information leaflet as this offers important information on our services.

Once we have completed your new patient health check & questionnaire, you will be registered with one of the GPs, however you are able to make appointments to see any of our GPs.

We ask you to make appointments in advance (usually 3 days) – if you require an urgent appointment you will be offered an urgent slot on the morning of your request – if your request is in the afternoon you will be seen in the afternoon. Please note, that urgent appointments are for urgent problems only, and you will be asked by the receptionists if you request an urgent problem so that you can be directed to the most appropriate service.

Home visits – home visits are for 'housebound' patients only and all visits should be requested before 10 am

Repeat medication – requests for medication must be made 48 hours in advance – we do not accept telephone requests for repeat medication – requests can be delivered, posted, faxed or emailed (find numbers on Practice leaflet). Please remember that once you've collected your prescription, it is your responsibility to ensure that it is safe and any medications prescribed are kept safe. **We will not issue duplicate scripts or lost or stolen medication.**

Unable to attend your appointment? We have a very strict policy on patients who persistently fail to keep their appointments. If you are unable to keep your appointment, please inform reception as soon as possible so that your appointment can be allocated to someone else. You will be removed from the practice list if you persistently fail to attend.

We strive to provide and deliver a high standard of medical care to all our patients and hope that you are appreciative of the efforts made by the Practice Team. We also expect standards of behaviour from our patients, these include politeness, courtesy and appropriate use of our services. If you have any cause for complaint or would like to suggest further improvements you can speak to the Practice Manager

Please sign this agreement to confirm that you have read and understood the guidance and that you agree to use the services provided by the practice appropriately and considerately:

Signed …… **Date ……**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE & HAND BACK TO RECEPTION TOGETHER WITH TWO FORMS OF ID (ONE PHOTOGRAPHIC & ONE WITH CONFIRMATION OF ADDRESS).

YOU WILL BE ASKED TO MAKE AN APPOINTMENT FOR A NEW PATIENT HEALTH CHECK. REGISTRATION AT THIS PRACTICE WILL NOT BE COMPLETED UNLESS YOU ATTEND FOR THIS APPOINTMENT.

NEW PATIENT QUESTIONNAIRE

Please complete the following information and attached forms. It is important that we have ALL your current details in order to process your registration. You can be assured that all information is confidential.

Todays date: …… DOB: ……

Your full name: ……...

Current address: …….

…….

Postcode: ……..

Home tel. no: …… Work tel. no: ……

Mobile no: ……. *can we use your mobile number to send text reminders and information about the services available YES/NO

Email : …….

*would you like to join our virtual Patient Participation Group YES/NO

Is this a permanent address: YES / NO

Are you intending to live at this address for the next 12 months: YES / NO

Previous address: ……..

……

Date of address change: ……..

Name & address of current doctor: ……

……

Reason for change: ……...

Medication

Do you take any regular medication? YES – NO

If 'yes', do you require your medication within the next month? YES – NO

Please list current medications:

……

……

……

……

PRACTICE POLICY ON HYPNOTICS AND ANXIOLYTICS

Any new patients currently prescribed hypnotics (sleeping tablets) or anxiolytics included in the list of medicines below, will be placed on a withdrawal regime at the time of registration unless a GP feels this is not appropriate.

Please sign a) or b) below:

a) I am not currently prescribed or taking any of the following medications:

b)

Diazepam, Flurazepam, Loprazolam, Lorazepam, Lormetazepam, Nitrazepam, Oxazepam, Temazepam, Zopiclone, Zolpidem and Zaleplon

Signature: ……Date: ……...

c) I am currently prescribed or taking at least one of the following medications:

d)

Diazepam, Flurazepam, Loprazolam, Lorazepam, Lormetazepam, Nitrazepam, Oxazepam, Temazepam, Zopiclone, Zolpidem and Zaleplon.
By registering with this practice I agree to be started on a withdrawal regime unless a GP feels this is not appropriate.

Signature: ……Date: ……

Ethnic Origin:

□	British	□	Irish	□	other white background
□	Carribean	□	African	□	other black background
□	Indian	□	Pakistan	□	Bangladeshi
□	other asian	□	Chinese	□	other ethnic group

Main language spoken: ……

Next of kin details: …… Emergency ContactTel: ……

Medical History

Please list all serious illnesses, operations or disabilities, together with the date of onset:

……

……

……

……

……

Have you suffered from:

Heart attack	YES – NO	……
Stroke	YES – NO	……
High blood pressure	YES – NO	……
Diabetes	YES – NO	……
Asthma	YES – NO	……
Chronic Airways Disease	YES – NO	……
Epilepsy	YES – NO	……
Hypothyroidism	YES – NO	……
Mental Health/ Depression	YES – NO	……

Allergies

Are you allergic to any medicines YES – NO

If 'yes' please list them: ……

Family history

Is there any family history of the following (if 'yes' please give details i.e. relationship and type of problem)

Heart disease YES / NO ……

Asthma YES / NO ……..

Diabetes YES / NO ……..

Stroke YES / NO ……...

Cancer YES / NO ……

Stomach probs YES / NO ……

Smoking status

1. DO YOU CURRENTLY SMOKE? YES / NO
   (if 'yes' please go to question 4)
2. IF 'NO' HAVE YOU EVER SMOKED? YES / NO
3. IF 'YES' PLEASE GIVE QUIT DATE ……
4. IF YOU DO SMOKE, WOULD YOU LIKE TO QUIT? YES / NO
5. HOW MANY CIGARETTES DO YOU SMOKE A DAY? ……

THE SMOKING CESSATION SERVICE OFFERS HELP & SUPPORT TO SMOKERS WISHING TO QUIT. THEY CAN BE CONTACTED ON : 01254 380424

Have you had a cervical smear in the last 3 years? (women only) YES – NO

Do you care for someone? YES – NO

Does someone care for you? YES - NO

DETAILS OF THE PERSON YOU LOOK AFTER

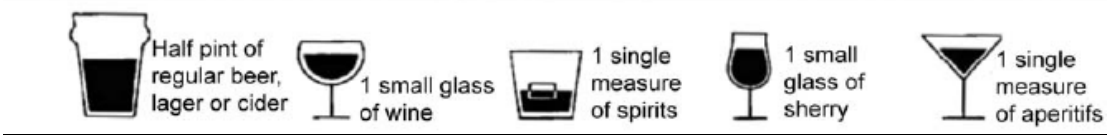
Name	
Date Of Birth	
ADDRESS (If Different From Above)	
Post Code	
Telephone Number (If Different From Above)	
GP Details (If Different From Your own)	

This Practice is working with Carers Contact to offer support to patients of any age who have caring responsibilities for someone who is ill, disabled or elderly. We appreciate the pressures carers are under and would encourage you to get in touch with Carers Contact who may be able to help.
Carers Contact is a free, confidential, support and information service for carers.

Please pass my details to the Carers Contact (tick) ☐

Please refer me to Adult Care Services for a Carers Assessment ☐

This is one unit of alcohol…



…and each of these is more than one unit

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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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	

PLEASE NOW RETURN THE COMPLETED FORMS TO RECEPTION.

REMEMBER WE REQUIRE TWO FORMS OF ID (ONE PHOTOGRAPHIC AND ONE CONFIRMING YOUR PRESENT ADDRESS)

YOU MUST ATTEND FOR YOUR NEW PATIENT HEALCH CHECK BEFORE WE CAN COMPLETE YOUR REGISTRATION AT THIS PRACTICE.

THANK YOU

STAFF INFORMATION ONLY:

Member of staff to confirm identification seen (please tick relevant box):-

Birth Certificate †	Driving Licence †	Passport †
Allowance Book †	Rent Book †	Utility Bill †
Other (please specify):-		
Identification Seen By:- (Member of staff name)		
Date identification seen		

Check signed agreement, check reason for changing GP, check medications & signed hypnotic agreement.

New Patient Examination

Date:

Nurse:

General exam

HEIGHT	**WEIGHT** (advice/referral if appropriate)
BMI	**BP**
SMOKING (advice/referral if appropriate)	**CHLYMDIA SCREEN** (urine screen 16-24)
ALCOHOL (advice/referral if appropriate)	**CVD RISK** (offer check 40-74)

Disease registers investigations

Heart (review IHD)	Chest (review COPD/asthma)
Diabetes (full review)	Hypertension (BP as per guidance)
Epilepsy (frequency/teratogenicity)	Hypothyroid (TFTs)
Mental Health (cholesterol, glucose, TSH if Lithium)	

Women only:

SMEAR HISTORY	**CONTRACEPTION** **LONG ACTING ADVICE**