New Patient Information Pack
Under 5 Years Old

Welcome to the New Springwells Practice

Please find enclosed the following:

1. Registration Form (purple)
2. New Patient Health Questionnaire
3. Sharing Patient Record Consent Form
4. Text Message Consent Form
5. Information on Child Health Clinics

Parents: Please complete the above forms and return to the surgery with your childs ID (e.g. birth certificate or passport).

New Patient Medical

- A New Patient Medical is only needed for a child under 5 years old if they are on medication. Please book them in at reception if this is needed when returning the forms.
- If your child is taking medication please bring the prescription list from your previous surgery or the boxes of medication themselves along to this appointment.
- We also require a list of your child's past vaccination history which can be faxed by your previous surgery to us on 01529 240520.

Useful Information

- Visit our website on www.ruralmedical.co.uk
- When you are registered we can provide you with a password for booking online Doctors appointments and ordering medication.
- The text message consent form provided will allow us to send you a reminder text message whenever you book an appointment.
- We ask that you give dispensary 48 hours notice when ordering repeat medication. Their telephone line is open from 10am – 4pm on direct telephone number: 01529 240888.
- There is a patient information file you may find helpful in both the reception and dispensary waiting areas for you to look at.

NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✔ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ 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 doctor while at that address

Address of previous doctor

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

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile 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_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

NHS Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register Date _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

New Patient Health Questionnaire

For Children Under 5 Years Old

This information is Confidential to the Practice and will form part of your Health Record.

1. CONTACT DETAILS

Surname:	
First Names:	
Date of Birth:	
Address:	
Telephone:	Home: Mobile: Parent Name/s: Email Address:
NHS Number:	
Ethnic Origin:	

Please circle Yes or No answers:

2. PAST MEDICAL HISTORY

Do you have any of the following? If so, you will be offered an Annual Assessment/Medication Review as appropriate.

Diabetes	Yes	No
Asthma	Yes	No
Other, please give details:		

3. Family History

Does any member of your family suffer from:

High Blood Pressure	
Diabetes	
Asthma	
Chronic Obstructive Airways Disease (COPD)	
Heart Disease	
Cancer	

4. General Health

Do You Have any Allergies?	Yes	No
Do You Take any Regular Medication? **Please provide a list of medication from your previous surgery or bring all medication with you on the day of your New Patient Medical with the Nurse. Thank you**	Yes	No
Do you Eat a Healthy Diet?	Yes	No
What is Your Weight?		
What is Your Height?		

5. Child Vaccinations:

Please bring the red book or ask your previous surgery to fax a list of the vaccinations your child has had to The New Springwells Practice on Fax: 01529 240520.

Child's Age (approx.)	Protection Against	YES	NO	Date Vaccine Given
8 weeks (2 months)	Diptheria/tetanus/polio/pertussis Haemophilus influenza type b (hib) Pneumococcal disease Rotavirus	☐	☐	
12 weeks (3 months)	Diptheria/tetanus/polio/pertussis Haemophilus influenza type b (hib) Meningococcal group C Disease (Men C) Rotavirus	☐	☐	
16 weeks (4 months)	Diptheria/tetanus/polio/pertussis Haemophilus influenza type b (hib) Pneumococcal disease	☐	☐	
1yr 1mth (13 months)	Measles, mumps & rubella (MMR) Pneumococcal disease Hib / Men C	☐	☐	
3 yrs 4mths	Diptheria/tetanus/polio/pertussis Measles/mumps & rubella (MMR)	☐	☐	

6. Any Other Notes / Comments

Sharing Patient Record Consent Form

I have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet “Your Electronic Patient Record & The Sharing of Information”.

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapist, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

SHARE – OUT (Please tick one of the options below)

I WOULD ☐ I WOULD NOT ☐

like the information recorded at The New Springwells Practice to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data

SHARE – IN (Please tick one of the options below)

I WOULD ☐ I WOULD NOT ☐

like the information recorded at other care teams who are involved in my care to be seen by members of the team at The New Springwells Practice, where I have granted those core teams the right to add to my shared data.

Patient Name	
Date of Birth	
Signature	
Date	

OR

Patient Name	
Patient Date of Birth	
Patient Representative Name	
Relationship to Patient	
Signature	
Date	

Your electronic patient record & the sharing of information

A patient's guide

Please read this leaflet carefully. It will give you information about the sharing of your electronic patient record and the choices you need to make.

Introduction

Today, electronic records are kept in all places where you receive healthcare. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

Your care service, however, uses a unique computer system called SystmOne that allows the sharing of full electronic records across different healthcare care services.

systmonline
BOOK REQUEST REGISTER

We are telling you about this as you register with a new NHS care service so that you can think about your choices:

You can choose to share your electronic record with other care services.

You can choose not to share your electronic record with other care services.

How is my decision recorded?

SystmOne has two settings to allow you to control how your medical information is shared:

1. Sharing OUT

   This controls whether your information enetered at this service can be shared with other NHS services (i.e. made sharable).

2. Sharing IN

   This controls whether information that has been made sharable at other NHS care services can be viewed by this care service or not (i.e. shared in).

How does this work?

Imagine you're receiving care from 3 different NHS services: your GP, a District Nurse and a smoking clinic. You want your GP and nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However you don't want the smoking clinic to see any of your other medical information.

Your sharing settings would be:

The GP can share information **IN** and **OUT**
The District Nurse can share **IN** and **OUT**
The smoking clinic can only share information **OUT**
but not **IN**

When you are first or next seen at the care service, you'll be asked the following questions:

1. Do you consent to the information that is recorded about you here being made available to other NHS care services that care for you and also use SystmOne?

If you answer YES

Clinicians at other services that care for you and use SystmOne will be able to see the information recorded here. For example, a district nurse that visits you would be able to see the data entered by your GP.

If you answer NO

The Clinician will be prevented from sharing the information entered here with other services caring for you.

2. Do you consent to allow this care service to view information about you that has been recorded at other services where you also receive care? (You must have separately consented for information to be 'shared out' of those services)

If you answer YES

This care service will be able to view information recorded on your patient record by other NHS services.

If you answer NO

This care service will not see any information recorded at any other NHS service (even if those services have the consent to share information out).

Note: You can still request for individual entries in your patient record to be marked as 'Private'. These will not be visible at any care service other than the one that recorded the information.

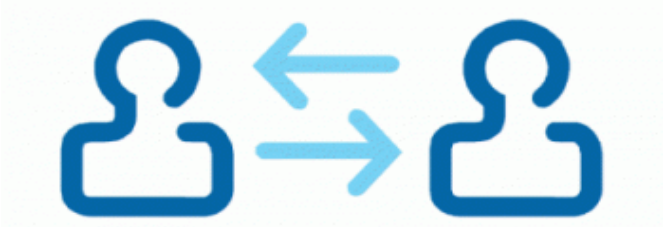
Why is this necessary?

These settings allow you to decide who can see the information on your electronic record. It also allows for joined care across different NHS settings which gives the best care and service to you.

Note: In some serious situations, for example if you are unconscious, clinicians will be able to access your electronic record without first asking your permission. Use of this is monitored.

Don't Forget

These seetings apply to any NHS service using SystmOne where you are currently receiving care. You can also change your sharing preferences at any time – just speak to a member of staff at this care service.



Your clinician should go through this leaflet in detail with you – if you have any additional questions, just ask!

What is SystmOne?

SystmOne is a clinical computer system produced by a company called TPP. It lets NHS staff record patient information securely onto a computer. This information can then be shared with other clinicians so that everyone caring for you is fully informed about your medical history, including medication and allergies.

SystmOne is currently used in GP practices, Child Health services, Community services, Prisons, Hospitals, Urgent Care & Out of Hours services, Palliative care services and many more.

www.tpp-uk.com

Text Messaging Consent Form

I would like to receive SMS text messages to my mobile telephone from The New Springwells Practice. This may include confirmation of an appointment or a reminder alert of clinics the surgery are running such as flu clinics.

Should I wish to withdraw consent I accept that I must give at least 5 working days notice in writing quoting the below mobile number. I will advise the practice if I change my mobile number and understand that a new consent form is required.

I am aware that the NHS mail messaging service is generated by a secure system however, they are transmitted over a public network on to a personal telephone and as such are not secure. The practice will not transmit any information that would enable an individual patient to be identified.

The SMS text service should not be solely relied upon, the responsibility of attending appointments or cancelling them still rests with me.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

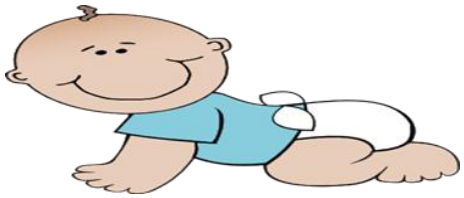
This service is only available to patients over the age of 16.

I confirm that I understand the above statement and that I am the patient listed below. I understand that it is my responsibility to advise The New Springwells Practice to stop sending texts to the mobile number listed.

Patient Name	
Date of Birth	
Mobile Number	
Signature	
Date	

*The practice does not share mobile phone contact details with any external organisations

Lincolnshire Community Health Services NHS
NHS Trust



IMPORTANT CHANGES TO THE

Child Health Clinics

With effect from 1st July 2014 Child Health Clinics will be appointment based and will be led by the Health Visiting Teams.

Please telephone 01529 306089 to book your appointment.

Clinics are held at Billingborough Surgery every 2nd & 4th Tuesday of each month from

2pm – 3.30pm

The Health Visiting Team can also be contacted on the above number for further advice.