SWISS COTTAGE
SURGERY

Gender: Male/Female	**Title:** Mr/Mrs/Ms/Miss/Dr	**Date of Birth:** ………/………/……………	**Place of Birth:** ………………………………

Surname: ……………………………… **First name:** ………………………………… **Date of arrival in UK (if not from UK):** ………/………/……………

Marital Status : ………

Address:
……………………………………………………………
……………………………………………………………
Post code:
…………………………………………………………

Home number: ………………………………… **Work number:** …………………………………
Mobile number: …………………………………… **Email address:** ……………………………………

<u>NEXT OF KIN</u> (for contact in case of emergency)

Their full name:	Relationship to you:	Their telephone number:
……………………………………………	…………………………………………	……………………………………
Do you give consent to discuss your medical problem with this person when they are contacted	Yes ( ) No ( )	

<u>HEIGHT</u>: ……………..cm **<u>WEIGHT</u>:** ………….kg **<u>BLOOD PRESSURE</u> (use machine in reception):** …………/……………

<u>EATING</u>

Do you have any special diet or eating plan? (e.g. diabetic, low fat, low salt, vegetarian)

……

<u>EXERCISE</u>

What type of exercise do you do? ……………………………………………………………………………………

How many days per week? ………………………………………………………………………………………………

<u>ALLERGIES</u>

Do you have any allergies? Are there any medications that you cannot take?

……

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VACCINATIONS

When was your last Tetanus vaccination? ..../.............../................................

Which other vaccinations have you had, and when?

....

To assist the NHS in providing the best service to all ethnic groups, please answer the following questions

To which of these ethnic groups do you feel you belong?

WHITE	ASIAN OR ASIAN BRITISH
[ ] British [ ] Irish Any other white background:	[ ] Indian [ ] Pakistani [ ] Bangladeshi Any other Asian background: ....
MIXED	**BLACK OR BLACK BRITISH**
[ ] White and Black Caribbean [ ] White and Black African [ ] White and Asian Any other mixed background:	[ ] Caribbean [ ] African Any other Black background: ....
CHINESE	**ANY OTHER ETHNICITY**
Chinese [ ]	Any other ethnic group: ....
I do not wish to answer this question	[ ]

1) **What is your main spoken language?**

   ....

2) **Do you need an interpreter to help you with spoken English?**

   [ ] I need an interpreter

   [ ] I do not need an interpreter

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MEDICAL HISTORY

Do you suffer, or have you ever suffered from any of the following? (Please circle)

Diabetes – Type I	Stroke	Chronic Airway Disease
Diabetes – Type II	Epilepsy	Emphysema
Hypertension	MS – Multiple Sclerosis	Cancer
High Cholesterol	Thyroid condition	Depression
Heart problems	Skin condition (e.g. Eczema)	Mental Illness
Angina	Asthma	

Are you taking any medications at present?

....

....

Have you had any surgery? Please give details, with dates

....

Do you have a close relative who had any of the following health problems before the age of 60?

Please state which family member /relative has this condition

Heart disease [ ]	Stroke [ ]	Diabetes [ ]	Asthma [ ]
....	....	....	....
Cancer [ ]	Hypertension [ ]	Asthma [ ]	High cholesterol [ ]
....	....	....	....

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ALCOHOL QUESTIONNAIRE - AUDIT C

1) How often do you have a drink containing alcohol?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 + times a week

2) How many standard drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 or 9	10 r more

3) How often do you have 6 or more standard drinks on one occasion?

Never	Monthly or less	Monthly	Weekly	Daily/almost daily

SMOKING

Do you currently smoke? Yes/No

IF YOU **DO SMOKE**:

1) How many per day? ....
2) What age did you start? ....
3) Would you like help to stop?

   Yes/No

IF YOU **DO NOT SMOKE**:

1) Did you smoke in the past? Yes/No
2) How many per day did you smoke?

   ....
3) Date when you stopped - ....

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********************WOMEN ONLY***********************

1) Are you currently using contraception? If yes, what type? ....

2) If you are on The Pill, what is the brand name? ....

3) Are you on Hormone Replacement Therapy? If yes, what is the brand name?

   ....

   Do you know about emergency contraception? If you require information please ask

FREE condoms are available from Reception

SMEAR TEST

1) What was the date of your last cervical smear test? ..../........./.....................

2) Where was the test done? (Please tick):

[ ] Previous GP surgery

[ ] Clinic

[ ] Private

3) Was it normal? Yes/No

4) Have you ever had an abnormal cervical smear test? (Please circle) Yes/No

If yes, please give date ..../........../..................

5) Have you had a hysterectomy? (Please circle) Yes/No

If yes, please give date ..../........../..................

6) If you are over 50, please give the date of your last mammogram:

........./........../..................

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CONTRACT

Between Patient and General Practitioner and his/her Clinical Staff

Confidentiality

We the Practice declare that we shall hold confidential all matters pertaining to the patient and not release such information without the Patients written consent.

Home Visit

I shall only request a home visit from the Practice under circumstances where I cannot physically attend the practice. I will endeavour to make this request no later than 10:00am.

Out of hours service

I agree to use the Out of Hours services ONLY WHERE it is medically necessary, otherwise I shall wait until the following morning and either attend the walk in surgery or request a home visit.

Mobile Phones

I agree to Switch Off my mobile phone before entering the Practice and to keep it switched off at all times while I am within the Practice Building.

Repeat Prescriptions

I agree to request Repeat Prescriptions giving the Practice two working day's notice of my need for medication. Furthermore I agree to make my request using the supplied request slip by hand, post, fax or email. I understand the request cannot be made by telephone.

Telephone Results

I understand that I can telephone for results of medical tests and I agree to phone during the advertised times.

Children on premises

Children have to be supervised at all times.

Treatment of staff

I agree with the policy of zero tolerance of abuse towards all NHS staff and I agree NOT to behave in an abusive, threatening or otherwise, aggressive manner with any member of the Practice Staff.

I acknowledge the right of the Practice to remove me from their list without appeal should I behave in a manner prohibited.

Please keep your belongings with you at all times as the Surgery cannot be responsible for lost or stolen items.

This agreement is between the patient and practice

Patient Name: ....

Patient Signature: ....

Date: ..../...................../...................................

SWISS COTTAGE SURGERY

SEXUAL HEALTH AND HIV SCREENING TESTS AT SWISS COTTAGE SURGERY

As a new patient to Swiss Cottage Surgery, we are pleased to offer routine screening for HIV, Sexual Health and other infections, for all our newly registered patients. It is by no means compulsory, but as a result of new government guidelines it is something we are recommending to our patients of 16 years and over, and is completely free of charge.

HIV is a virus which is spread by a number of methods such as sexual contact, from mother to baby, and through contact with blood products if they are contaminated with the virus. It can affect your immune system and over time your immunity may be permanently affected. This virus is not curable, but its effects can be limited using medication, which are more effective if started early.

Chlamydia is the most common bacterial sexually transmitted infection (STI) in the UK, being the most common in men and women under 25 years of age. There is an even higher rate of infection in Camden than in the rest of the UK. Many people have no symptoms and do not know that they have it. If Chlamydia is not treated, it can spread to other parts of the body. However, if you know you have it, it can be easily treated. For further STI screening, please make an appointment to see Nurse Judith, or sexual health nurse.

We at Swiss Cottage highly recommend these tests. Please indicate if you wish to have the tests by ticking the appropriate response below.

Would you like a free HIV test?

Yes [ ]

No [ ]

Are you under 25 and sexually active?

Yes [ ]

No [ ]

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SUMMARY CARE RECORD:

Your emergency care summary

What is the Summary Care Record?

It is NHS centrally held electronic record which contains:

- Your recent and current **Medication** (from last 12 months)
- **Allergies** you suffer from
- Any **Adverse Reactions to Medicines** you have had.

Why do I need a Summary Care Record?

Summary Care Records are being introduced to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record, it will give healthcare staff faster, easier access to essential information about you, and help to give you safe treatment during an emergency, when admitted to hospital or when your GP surgery is closed.

For example, a person who lives in London is on holiday in Brighton. One evening, they're knocked unconscious in a car accident and taken to an accident and emergency (A&E) department. Under the current system of storing health records, it would be difficult for A&E staff to find out whether there are any important factors to consider when treating the person (such as any serious allergies to medications), especially as their GP surgery is likely to be closed. If healthcare staff cannot get the relevant health information quickly, some patients may be at risk.

A Summary Care Record is an electronic record that's stored at a central location. As the name suggests, the record will not contain any other information about your medical history. It will only contain: your last 12 months medication, your allergies and adverse reactions to medicines.

Who can see it?

Access to your Summary Care Record will be strictly controlled. The only people who can see the information will be healthcare staff directly involved in your care who have a special smartcard and access number (like a chip-and-pin credit card).

Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, e.g. because you're unconscious, healthcare staff may look at your record without asking you. If they have to do this, a record will be made.

How do I know if I have one?

Summary Care Records are now in Camden and all patients will have a summary care record created, and it will include just their medications (last 12m), allergies and adverse reactions to medicines.

Do I have to have one?

No, if you choose not to have one, then you will need to complete a form and bring it along to the surgery. You can download a form, or obtain one from your surgery. You can change your mind at any time – just tell your Practice.

More Information

For further information visit www.nhscarerecords.nhs.uk, email scr.comms@hscic.gov.uk or call the information line on 0300 303 5678 option 2.

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Recording Consent of New Patients for Data Sharing Initiatives in Camden

Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care.	I want to: Opt in to CIDR. ☐ If Opting out please complete additional attached form
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐
Care.data National Initiative	Care.data aims to make increased use of information from medical records with the intention of improving healthcare via research.	I want my medical record to be part of Care.data. ☐ There are **2 levels of opt out**, you can opt out of both: I do not want my personal and confidential data to leave the Health and Social Care Information Centre ☐ I do not want my personal confidential data to leave the GP Practice ☐

Please read the above text and make your selection by ticking the box or boxes next to the right statement. Then please fill out the required information below, sign and date the form and return it to reception.

Name: ....

Date of Birth: ....

Signature: .... **Date:** ....