

Dear Patient

REGISTRATION WITH OUR PRACTICE

WELCOME

Thank you for choosing the St James Medical Centre Partnership. Your official registration is with the Practice as a whole but you will be allocated a named 'Usual GP' immediately upon completion of the registration paperwork. The Practice operates from two sites:-

Main Surgery

St James Medical Centre, Coal Orchard, Taunton. TA1 1JP

Branch Surgery

Orchard Medical Centre, Norton Mills, Morse Road, Norton Fitzwarren. TA2 6DG

Patients can choose to be seen at either site subject to appointment availability. Please note that for urgent care you may have to be seen at our main site.

Download our practice booklet direct from our website at www.stjamesmedicalcentre.co.uk

ELIGIBILITY

To be eligible for registration with us you must:-

- Live at an address within our catchment area
- Be entitled to receive NHS treatment in the UK
- Complete all the necessary forms

FORMS TO COMPLETE

As a minimum, you will need to complete :-

- NHS form GMS1 – Family Doctor Services Registration
- New Patient Information Form
- Alcohol Consumption Questionnaire

There are two matters relating to your records that you need to review:-

a. Summary Care Record

If you do nothing, you automatically opt-in. Please complete the relevant form if you wish to opt-out. We encourage you remain 'opted-in'

b. GP Online

We strongly encourage all patients with online access to sign up for this service. Please see the leaflet enclosed.

CHECKLIST

To complete your registration request please ensure you have all the items listed below.

a) Compulsory

- GMS1 Form – Family Doctor Services Registration
- New Patient Information Form
- Alcohol Users Questionnaire

b) Optional but strongly encourage

Ask our Patient Services Assistant about registering for GP Online



THANK YOU

REGISTRATION - PATIENT HEALTH QUESTIONNAIRE (ADULTS) – 15 and over

Please complete this form as fully as possible, as we are unable to complete your registration without this information

Registration and Family Details

Surname Forename(s).....
NHS No: Previous Surname(s)
Title (Mr./Mrs./Miss etc.) Date of Birth.....
Address.....
Post Code Email.....
Home Tel. No. Mobile No.....
Occupation Are you a Military Veteran? Yes / No

Is English your first language? Yes/No If No, what is your first language?

Ethnic Group (please tell us your ethnicity below)

.....
(If you are unhappy to provide this, we will note your record to indicate that it was declined.)

Proof of address provided? Driving Licence Passport Utility Bill
Allowance Book Solicitor's Letter Offer of Tenancy
Other Proof:.....

Online Services

Please register for GP Online. This will enable you to make your own appointments, order your repeat prescriptions on-line and see basic summary information about your health records such as your allergies, adverse reactions and medications.

Yes, I would like to register No, I do not wish to register

Your Summary Care Record

Your Summary Care Record allows other health care professionals to access your high level medical records with your permission. You are automatically opted in. Please tick your preference.

Yes, I consent to Summary Care Record No, I do not want a Summary Care Record

If this section is left blank a Summary Care Record will be completed for you.

Accessible Information

Do you have any special communication needs? Yes No

If yes, please give details and explain what support would be helpful

.....
What is your preferred method of communication? (Please circle)
Letter / Email / Telephone

Please indicate whether you consent to us sharing your communication needs with other NHS and Adult Social Care Providers: YES/NO

Prescriptions

I consent to collecting my dispensed prescription from the following pharmacy.....
Please note, if you receive repeat medications, please bring in a copy of your current prescription.

About You

Do you have a carer? YES/NO If yes, please give details.....
Are you a carer? YES/NO If yes, please give details
Are you registered disabled? YES/NO If yes, please give details
Are you allergic to any medicines and if so which?

Your height Your weight

Smoking

Do you currently smoke? Yes/No { If Yes, how many cigarettes
If no, have you ever smoked? Yes/No { or ounces of tobacco per week?
(If you are unhappy to provide this information, we will just note your record to indicate that it was declined.)

Please let us know is you would like smoking cessation advice.

Family History

Please state any serious illness, in particular heart disease, strokes or diabetes.
.....
.....

Next of Kin

Please give name, address and telephone number of next of kin
.....

Patient Group

We have an active Patient Group

Would you like to receive information about their work?	Yes / No
Would you be happy for the Patient Group to contact you occasionally by email to seek your opinion?	Yes / No

Consent

I consent to receive text messages to confirm and remind me of appointment bookings (except for under 18 years who are opted out automatically).	Yes / No
I consent to receive occasional emails from the Practice informing me of services / seek feedback. (You will not be contacted by email for personal health matters)	Yes / No

*You are automatically 'opted-in' unless you advise us that you wish to opt out

Signed **Date**

If you have any administrative or health matters arising from this form, please feel free to contact our reception team.
Revised – November 2016

Organ Donation

A leaflet is available on our website regarding registering for organ or blood donation. This is optional and separate from your registration with the Practice. It is easy for you to self-register on the NHS Blood and Transplant website at www.nhsbt.nhs.uk. If you would prefer to talk to someone you can telephone the NHS Blood and Transport Helpdesk on 0300 123 2323.

St James Medical Centre
Alcohol Users Questionnaire (AUDIT)

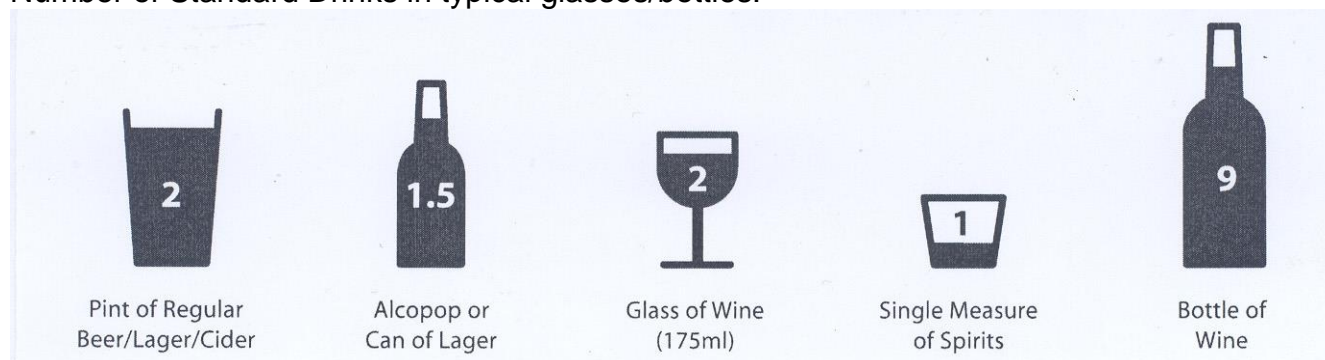
Title, Initials & Name: **Date Of Birth**.....
(Please note that you should only complete this form if you are aged 16 and over at the time of registration)

Address:

Please ring the one answer out of the 3 or 5 options per question that most represents your consumption: Please Note that the Practice will calculate your score. Once completed please return this form to the staff at St James or Orchard Medical Centre together with all other forms you have been asked to complete at registration.

Questions	Scoring scheme					Score
	0	1	2	3	4	
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 or more 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 8	10 or more	
3. How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. 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	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes during the last year	
10. Has a relative or friend or a doctor or health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes during the last year	
					Total	

Number of Standard Drinks in typical glasses/bottles:



All information in this document will be treated in confidence and used by your registered GP to assist with health related matters only.

FOR OFFICE USE ONLY – Please complete all boxes

EMIS Number.....

	Yes/ No	Initials
Patient address confirmed - one of the following -driving license , passport, utility bill, medical card (do <u>not</u> scan copies as proof and do not stop registration if not available)		
Patient advised of named GP and medical record coded accordingly = 9NN60 and 67DJ		
If applicable, Summary Care Record opt-out coded (9Nd0 on EMIS web – Registrations – Sharing Consent – SCR – Express Dissent)		
If under 18, SMS text message facility (EMIS Web – patient messaging – opt out – Yes)		
GP Online sign-up completed <ul style="list-style-type: none"> • 1 x photo identification • 1 x utility bill or other invoice including the patient's address 		
Residential coding (EMIS Web – Primary Care – Residential Coding)		
Accessible Information (special communication needs) <ul style="list-style-type: none"> • Coded • Alert added to system • Label added to notes 		



ONLINE ACCESS TO THE PRACTICE

Patient Access allows you 24 hour access to:-

- Checking, booking and cancelling appointments.
- Ordering repeat medication and checking your medication.
- Updating your contact information, including mobile phone number and email address.
- Viewing aspects of Medical Records.

If you have online access, please don't delay; sign up today whilst you have proof of your identity. Simply ask at Reception and one of our Patient Services Assistants will provide the registration document required.

We encourage all patients with online access to use this service as it is quick and convenient.