Welcome to Castlehead Medical Centre and thank you for collecting the forms you'll need to complete to register here as a patient. In your welcome pack you will find the following:

- **The NHS GMS1 (Purple).** Please ensure that you sign this where highlighted, as it is not at all clear, and consider the NHS donor section at the bottom of the form. Another signature is required for this section. Please turn the form over if you are not ordinarily resident in the UK as there is another section there to be completed if this is the case.

- **New Patient Questionnaire.** Please complete this to the best of your ability to help us take the best possible care of you until we receive your full medical records. It would be very helpful if you could include contact phone numbers in case we have any queries with your registration.

- **Summary Care Record Letter.** Please ask for an 'Opt Out form' if you do not wish to be included in the Summary Care Record Scheme.

- **General Practice Physical Activity Questionnaire.**

- **Patient Online Records Access.** Completing this will enable you to book appointments on-line, order repeat prescriptions and have access to some of your medical records.

- **Pharmacy/ Prescription Details.** Please complete and return the bottom section of the form and keep the top half for reference.

- **Repeat Medication:** If you take regular medication please make an appointment to see a GP in plenty of time to arrange a repeat prescription. It would be helpful if you brought your medication with you.

- **New Patient Health Check.** We invite all new adult patients to make an appointment for a Health Check with one of our Health Care Assistants.

- **Consent form** Please note we are unable to discuss your medical record with any third party unless you complete a consent form.

Only the first two forms need to be completed for under 16s plus the Prescription preference form

Please return these forms to reception and bring with you **two forms of identification, preferably one photo ID and one showing your address**. We will process these as quickly as possible and you will be registered here within a few days.

NEW PATIENT HEALTH QUESTIONNAIRE

Castlehead Medical Centre

Ambleside Road, Keswick CA12 4DB

Tel 017687 72025

FIRST NAMES	
SURNAME	
Date of Birth	
Marital Status	

TEL NO	
WORK NO	
MOBILE NO	
E-MAIL	
DO YOU GIVE CONSENT TO US CONTACTING ABOUT YOUR HEALTH IN THE FOLLOWING WAYS (PLEASE TICK ALL THAT APPLIES)	**HOME TEL** ☐ **MOBILE NO** ☐ **EMAIL** ☐
DO YOU AGREE TO TEXT MESSAGING SERVICE	**YES** ☐ **NO** ☐

DO YOU WANT TO REGISTER FOR PATIENT ONLINE ACCESS? (Proof of Identity Required)	**YES** **NO**			
Proof of Identity (one photo, one proof of address)	**BIRTH CERTIFICATE**	**DRIVING LICENCE**	**PASSPORT**	**UTILITY BILL**
	ALLOWANCE BOOK	**SOLICITORS LETTER**	**OFFER OF TENANCY**	**BANK STATEMENT**
	WAGE SLIP	**OTHER**		

OCCUPATION (IF RETIRED PLEASE STATE PREVIOUS OCCUPATION)	

ETHNIC GROUP – WOULD YOU DESCRIBE YOURSELF AS…..	**WHITE ☐ BLACK ☐ ASIAN ☐ MIXED ☐** **BRITISH ☐ CARRIBEAN ☐ INDIAN ☐ WHITE+BLACK CARRIBEAN ☐** **IRISH ☐ AFRICAN ☐ PAKISTANI ☐ WHITE+BLACK AFRICIAN ☐** **CHINESE ☐ WHITE+ASIAN ☐** **OTHER PLEASE SPECIFY ……..**
WHAT IS YOUR FIRST LANGUAGE **DO YOU REQUIRE AN INTERPRETER** **DO YOU HAVE ANY COMMUNICATION NEEDS SUCH AS BRAILLE/LARGE PRINT/EMAIL**	**YES ☐ NO ☐** **PLEASE SPECIFY**

HAVE YOU TRAVELLED OUTSIDE THE UK IN THE LAST 2 YEARS. IF SO WHERE?	
Have you ever served in the Armed Forces? If so please state when. (13Ji)	
Are you a family member of serving Armed Forces personnel ? (13WW)	
Are you a family member of former Armed Forces personnel? (13WV)	

ARE YOU HOUSEBOUND (13CA)	**YES ☐ NO ☐**
DO YOU LIVE IN A CARE/NURSING/RESIDENTIAL HOME	**CARE ☐ (13FX) NURSING ☐ (13F61)** **RESIDENTIAL ☐ (13FK)**

ARE YOU REGISTERED AS DISABLED	**YES ☐ NO ☐**
DO YOU HAVE A CARER	**YES ☐ NO ☐ PLEASE GIVE CONTACT DETAILS** **NAME-** **ADDRESS-** **RELATIONSHIP-** **TEL NO-**
ARE YOU A CARER	**YES ☐ NO ☐** **IF YES PLEASE ASK RECEPTION FOR A CARERS FORM.**
DOOR ACCESS KEY CODE - IF APPLICABLE	

CONTACT IN CASE OF EMERGENCY/NEXT OF KIN **This is a person whom you give consent to be contacted in an emergency**	**NAME** **ADDRESS** **RELATIONSHIP** **TELEPHONE NUMBER**
DO YOU HAVE ANY KNOWN ALLERGIES. IF YES PLEASE STATE	
CURRENT MEDICAL CONDITIONS (PLEASE LIST CONDITION (AND APPROX YEAR DIAGNOSED) DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/ MENTAL HEALTH PROBLEMS/ HEART DISEASE/ HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS	
FAMILY HISTORY – IS THERE ANY FAMILY HISTORY FOR THE FOLLOWING ILLNESSES- DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/ MENTAL HEALTH PROBLEMS/ HEART DISEASE/ HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS	
PLEASE LIST ANY CURRENT MEDICATION NAME/STRENGTH/DOSE	

HAVE YOU EVER REFUSED TREATMENT/SCREENING OF ANY KIND AND IF SO WHAT?	

DO YOU DRINK ALCOHOL	**YES or NO**
IF YES HOW MUCH ALCOHOL DO YOU DRINK AND HOW OFTEN? **(SEE ATTACHED FORM FOR GUIDANCE)**	**NUMBER UNITS PER WEEK =**

SMOKING STATUS	**NEVER SMOKED ☐ CURRENT SMOKER ☐** **EX-SMOKER ☐** **Date stopped…….**
CURRENT SMOKERS ONLY - **WHAT DO YOU SMOKE** **(CIGARETTE/PIPE/ROLL YOUR OWN/DRUGS/CIGARS)** **HOW MANY PER DAY** **DO YOU WANT HELP TO STOP SMOKING?**	**YES ☐ NO ☐**

WOMEN ONLY

DATE OF LAST CERVICAL SCREENING & RESULT (if known)	
DATE OF LAST MAMMOGRAM & RESULT (IF APPROPRIATE)	
MMR STATUS (MEASLES/MUMPS&RUBELLA) IF KNOWN	
IF YOU HAVE ANY CHILDREN, IN WHAT YEARS WERE THEY BORN	
DO YOU HAVE A CONTRACEPTIVE IMPLANT OR COIL FITTED **PLEASE SPECIFY**	**DATE FITTED TYPE**
DO YOU USE ANY OTHER FORM OF CONTRACEPTION **PLEASE SPECIFY**	

DO YOU HOLD THE FOLLOWING DOCUMENTATION – THE DOCUMENTS LISTED BELOW ARE REGARDING YOUR PERSONAL WISHES IN RESPECT TO ANY FUTURE MEDICAL TREATMENT, IF YES PLEASE BRING FORMS INTO THE PRACTICE SO THAT WE CAN RECORD THIS INFORMATION CORRECTLY ON YOUR MEDICAL RECORD.

DNA/CPR (DO NOT RESUSCITATE)	**YES ☐ NO ☐**
ADVANCED DIRECTIVE	**YES ☐ NO ☐**
POWER OF ATTORNEY WELFARE	**YES ☐ NO ☐**
POWER OF ATTORNEY PROPERTY AND AFFAIRS	**YES ☐ NO ☐**

By signing this form you have consented to a Summary Care Record being created for your emergency care, please see the enclosed letter for details. If you wish to Opt Out of this please ask for the relevant form.

If you wish to Opt Out of the sharing of your GP records to the Health and Social Care Information Centre, via the General Practice Extraction Service, or to learn more about this, please visit *www.nhs.uk/your-nhs-data-matters* or telephone 0300 3035678.

SIGNATURE _____ DATE_____

All new patients who have repeat medications only need to make a 10 minute appointment to see the GP
All new patients over 16 years old and who are not on any repeat medication need a 20 minute appointment with the Health Care Assistant.

Your registered GP will be one of the following :
Dr P Hemingway, Dr T Hooper, Dr A Westwell, Dr K Winterbottom, Dr C Ferris, Dr C Haslam, Dr D Brigham

Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that

if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record** –. **Please ask GP practice staff for an 'opt out' form, complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) **(01228 602128.),** GP practice staff, or **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out.
If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Practice Manager

APPENDIX 2: GENERAL PRACTICE PHYSICAL ACTIVITY QUESTIONNAIRE

General Practice Physical Activity Questionnaire

Date ……..

Name…….

1 Please tell us the type and amount of physical activity involved in your work. Please tick one box that is closest to your present work from the following five possibilities:

		Please tick one box only
A	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
B	I spend most of my time at work sitting (such as in an office)	
C	I spend most of my time at work standing or walking. However my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, child minder, etc.)	
D	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
E	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2 During the *last week*, how many hours did you spend on each of the following activities?

		None	Some but less than an hour	1 hour but less than 3 hours	3 hours or more
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
B	Cycling, including cycle to work and during leisure time.				
C	Walking, including walking to work, shopping for pleasure etc.				
D	Housework/childcare				
E	Gardening/DIY				

3 How would you describe your usual walking pace? Please mark one box only.

Slow pace less than 3mph	Steady average pace	Brisk pace	Fast pace over 4 mph

Standard alcoholic units

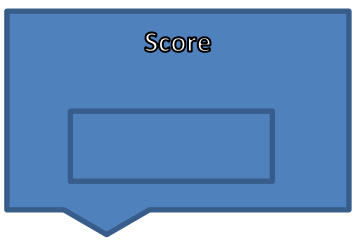
unit is typically: Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)	
The following drinks have more than one unit: A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)	

Appendix 3: Alcohol screening using **FAST**

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**your score**
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	
How often during the last year have you failed to do what was normally expected from you because of 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	

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.



Castlehead Medical Centre
Prescriptions

If you are taking medication we can send your prescription to a nominated pharmacy for you, or if you live a mile away from a pharmacy you can use our own dispensing facilities. Reception and dispensary staff will be able to advise you if we are able to dispense to you.

It would help us to process your prescription more efficiently if you could please nominate a pharmacy or our own dispensary by indicating below where you would like to collect future prescriptions from (this can be changed at any time by asking our dispensary staff to arrange this for you).

To order repeat prescriptions please either:

- Complete the White Slip showing the list of drugs that you can order as repeat issue.

  Please mark only those items that you need by ticking each item on the White Slip within 5 days of running out.
  Please do not tick items that you do not need.
  You can hand this in to your nominated pharmacy or deliver to the Medical Centre and post in the box by the side of our dispensary
- Call our dedicated Repeat Prescription Line on 017687 80125
- Order on line via our Website www.castlehead.org.uk Once you have registered to access this facility
- Order using the myGP App on your mobile

Please allow at least 96 working hours excluding weekends and Bank Holidays before collection.

……✂……

Please take the completed form to the dispensary

Pharmacy/ Dispensary Nomination

Name ……..

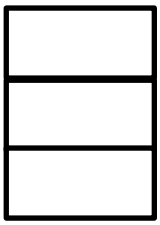
Date of Birth ……..

Address ……..

Castlehead Medical Centre Dispensary

Boots, Main Street, Keswick

Cohens Pharmacy, Station Street, Keswick



Other …… Signature…….

Action	Actioned	Date	Action	Actioned		Date
New prescription destination added			Informed about electronic repeat dispensing	Yes	No	
Old nomination removed						
Nominated for EPS prescriptions						

NOTES:

Dr. T. M. Hooper
Dr. K. Winterbottom
Dr. P. E. Hemingway
Dr. Alison E. Westwell

Castlehead Medical Centre
Ambleside Road
Keswick
CA12 4DB

Telephone 017687 72025

CONSENT TO DISCUSS MY MEDICAL INFORMATION

Including 13-16 year olds

(Patient name).....date of birth……..

of address……..

Give my consent to Castlehead Medical Centre to provide my personal medical information to the nominated person(s) named below which must be adequate, relevant not excessive and accurate:

1. Consent given to (name).....

Relationship to me**.....**

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

2. Consent given to (name).....

Relationship to me**.....**

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

If you would like to add any exclusion to this, please list these below, otherwise we will accept this as consent given to discuss or disclose anything in your medical records.

Items to be excluded: ……

……

I understand that this consent form will remain in place until I give written advice to Castlehead Medical Centre to have this withdrawn and I accept that it is my responsibility.

Signed……Date……

Office use only	Date	Initial
Alert added to patient record, including contact tel numbers of 3rd party		
Code added 9NdG		