***Broseley Medical Practice Medical Practice***

**Patient Questionnaire**

To help us maintain accurate patient records we would be very grateful if you could spend a few minutes completing this short questionnaire.

Once you have completed this form please return it to Reception.

**Name**:………………………………………………… **Date of Birth**:….....................................

(full name in capital letters please)

**Home Telephone number: ………………………………………………………………………...**

**Mobile number: ………………………………………………………………………………………**

**Email Address:…………………………………………………………………………………………**

We send out electronic alerts of health campaigns/appointment reminders/Practice Information. Please tick the box if you are happy to receive information as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TEXT |  | EMAIL |  | BOTH |  |

Do you have any difficulties communicating, eg profoundly deaf, blind or speech impairment following illness/surgery? **Yes / No** (please circle as appropriate)

…………………………………………………………………………………………………………………….

If **Yes,** how can we help make information from the Practice more accessible to you? Eg large print information/use email/other

……………………………………………………………………………………………………………………

What is your first/ spoken language:…………………………………………………….……………………

Do you have a “Living Will” (a statement explaining what medical treatment you would not want in the future)?

|  |
| --- |
| **Yes/No** (please circle as appropriate)If **Yes** please bring a written copy to your New Patient Medical |

|  |
| --- |
| **Yes/No** (please circle as appropriate)If **Yes** please bring a written copy to your New Patient Medical |

Have you nominated someone to speak on your behalf, (eg a person who has Power of Attorney)?

**SPECIFIC NEEDS**

Please detail below any specific needs you have so the Practice can ensure they are identified, recorded, and appropriate action taken.

|  |  |
| --- | --- |
| Please state any sensory impairment you have (ie speech, hearing, sight) |  |
| Are you an Assistance Dog user? | **Yes/No** (please circle as appropriate) |
| Please state any physical disabilities you have |  |
| Please state any mental disabilities you have |  |
| Please state any requirements you have to be able to access the Practice premises |  |
| Please state any religious or cultural needs |  |
| Do you require the help of a translator/interpreter? | **Yes/No** (please circle as appropriate) |
| Please state any specific nutritional requirements you have |  |
| Please state any phobias you have |  |
| If you are a carer, please state the name and address of the person you care for |  |
| If you have a carer please state their name/address/phone number and sign here if you wish us to disclose information about your health to your carer. |  |
| Signed: Date:  |

|  |  |
| --- | --- |
| **Female Patients only** |  |
| Do you currently have a coil or contraceptive implant fitted? **Yes/No** (please circle as appropriate)If you use an alternative contraceptive, please note this below. | If **Yes** please tick relevant option:Mirena CoilCopper CoilNexplanon**Date Above Fitted:**  |
| What was the date of your last smear? | What was the result of your last smear? |
| Date of last Mammogram (if applicable) | Have you had a Hysterectomy? |

**Thank you for completing this form**

 

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

**Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

**Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

**Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form below, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

**For GP practice use only**

To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below:

|  |  |  |
| --- | --- | --- |
| **Summary Care Record Consent Preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only) | 9Ndm. | XaXbY |
| The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn. | XaXbZ |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo. | XaXj6 |