Salisbury House Surgery

Lake Street, Leighton Buzzard, Bedfordshire, LU7 1RS
Tel : 01525 243890 Fax : 01525 854898
Dr C D W Marshall, Dr F J Dry, Dr M Hoque,
Dr P Vogwell, Dr M Teehan
Practice Manager: Zadie Hartwig
www.salisburyhousesurgery.co.uk email: salisburyhouse@nhs.net

New Patient Registration

Thank you for your request to Register at Salisbury House Surgery. We would like to welcome you to the practice.
Please find accompanying this letter the Registration Pack which you will need to complete in order for us to Register you with our Surgery.
Everyone Registering at the Surgery **must complete** and sign the NHS form GMS1 (the purple form).

You must complete the NHS Number (Contact your previous Surgery if necessary).

Submit this information in person between 08:00 to 18:00 hours.

You are required to produce evidence of identity:

- Photographic Proof of ID – Passport or Photo Card Driving Licence.

To qualify for NHS treatment you must be resident in the UK and be able to prove your eligibility.

For UK and European Economic Area (EEA) nationals you will need to provide:

- Tenancy / Leasing Agreement.
- Council Tax / Utility Bill Showing Your Name.
- Copy of Work Contract or Letter from Employer Stating Length of Employment.
- Letter from College / University Proving Registration & Attendance of Course.

People not covered by EEA are required to provide:

- Passport & Visa Which Clearly State the Right to Reside. (NOT a visitor visa).

You will also be required to Complete our Patient Information Questionnaire. This will allow us to have initial information about you whilst we wait for your medical records to arrive from your previous Practice. You must complete the Questionnaire – failure to do so will result in you not being Registered. **Nursing / Care Homes will need to submit an Advanced Care Plan when Registering their patients.**

Please allow 48 hours for your Registration to be processed. Once you are Registered on our system you will be able to book a New Patient Health Check with a member of our Nursing Team.

Please visit our Website www.salisburyhousesurgery.co.uk for further information regarding Opening Times, Staff and Services we provide.

We are a Summary Care Record Practice. If you wish to opt out of this scheme please download the form from our website (under the Medical Records Tab) or ask a member of the Reception team for a form.

The practice has Patient Participation Group (PPG)
PPG would be very interested to hear from patients who would like to join this group. Members of the group would welcome patients ages 16 and over. Your views can help shape the services we offer in our practice. For further details you can visit www.salisburyhousesurgery.co.uk or alternatively you can email PPG on: **shsppg@outlook.com**

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Online Registration Form

Salisbury House Surgery offers an Online Service for Booking and Cancelling Appointments. This Service also allows you to order you're Repeat Prescriptions. You can find this Service at www.SalisburyHouseSurgery.co.uk

Please indicate below if you would like your Username and Password posted to you once you are Registered.

Please Circle: Yes No

Name: .....

Date of Birth .....

Address: .....

Child's Name: .....

Signature: .....

If requesting on behalf of a child under the age of 16 please indicate relationship:

Please Circle: Mother Father Other: .....

SALISBURY HOUSE SURGERY, LAKE STREET, LEIGHTON BUZZARD

PATIENT INFORMATION QUESTIONNAIRE

You need to complete this form before we can Register you

This form is lengthy but it helps to plan services. All information you provide will be treated in strict confidence and in accordance with all data protection legislation. **PLEASE BOOK FOR A NEW PATIENT CHECK WITH A NURSE BEFORE SEEING THE DOCTOR.**

PERSONAL DETAILS (Please complete in block capitals as appropriate)

Family Name: ..... **First Name:** .....

Address: .....

Post code: ..... **Date of Birth:** .....

Occupation: .....

Home telephone: ..... **Work telephone:** .....

Mobile telephone: ..... **Do you consent to the Practice sending you SMS text messages? YES / NO (If this is not answered your questionnaire will be returned to you).**
(Please indicate (by circling) which number you would prefer us to contact you on during the day)

Email address: .....
Are you agreeable to receiving information from Salisbury House Patient Participation Group - YES / NO please circle.

Name of next of kin ..... **Relationship to you:** .....

Next of kin contact telephone: .....

What is your ethnicity group? Please tick next to the category.

White	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Other ethnic group**
British	White and Black	Indian	Caribbean	Chinese
Irish	Caribbean	Pakistani	African	Vietnamese
Other white – please specify	White and Black African	Bangladeshi	Other Black background	
	White and Asian	Other Asian background		
If none of the above please specify				
Prefer not to state ethnic group ☐				

What is your main spoken language? .....
Are you ex-armed forces? .....

DISABILITY/SPECIAL NEED
Do you have any disability or special needs, including visual or hearing impairments? If so, please describe below:

.....

CARER DETAILS

A carer is a person who looks after a relative, friend or child with a physical or learning disability; or who has a mental health problem, a long term illness or who is frail. This definition does not include those who are paid carers.

Are you a carer? **YES ☐** **NO ☐**
Do you have a carer? **YES ☐** **NO ☐**

Your carer's name: .....

Your carer's telephone number: .....

YOUR MEDICAL HISTORY

Do you have any ongoing/significant medical history?.....

.....

MEDICATION

If you need regular prescriptions please make an appointment to see a Doctor before your next medication is required. We are unable to issue any prescription until you have discussed your medication with a GP.

Do you have any drug allergies: **YES ☐** **NO ☐**
If yes, please list what these are: .....

Please nominate the Chemist you would like to collection your Prescription/Medication from:

.....

EXERCISE

Do you take 30 minutes of vigorous activity five times a week which increases your heart rate?

YES ☐ **NO ☐**

DIET

Do you have a varied diet including the recommended 5 portions of fruit/vegetables a day?

YES ☐ **NO ☐**

CONTRACEPTION & SEXUAL HEALTH

We offer a full range of contraception services, including emergency contraception (the 'morning after pill' and confidential advice about sexual health matters. Please ask for an appointment with our Practice Nurse. Chlamydia is screened free of charge at the surgery. Please collect a testing pack from reception if you are under 25 years old.

DO YOU SMOKE CIGARETTES? YES ☐ NO ☐

If yes, how many cigarettes do you smoke every day? .....
If no, but you have smoked in the past, when did you stop? .....
How many did you smoke every day before you stopped? .....

Tobacco smoking is the biggest cause of premature illness and death. IF YOU WANT HELP TO STOP WE CAN REFER YOU TO A SMOKING CESSATION ADVISOR. Stopping smoking is the single most important step you can take to reduce the risk of having a heart attack and to live longer.

ALCOHOL

How often do you have a drink containing alcohol?

Never ☐ Monthly or less ☐ 2 to 4 times a month ☐
2 or 3 times a week ☐ 4 or more times a week ☐

(One unit = ½ a pint of normal strength beer **or** 1 small glass of wine or 1 single measure of spirits)

How many units of alcohol do you have on a typical day when you are drinking?
1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more ☐

How often have you had 6 or more units if you are female and 8 or more if you are male in a single occasion in the last year?
Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily ☐

How often during the past 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 ☐

How often during the past year have you failed to do what was normally expected of you because of drinking?
Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily ☐

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 ☐

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 ☐

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 ☐

Have you or somebody else been injured as a result of your drinking?
No ☐ Yes but not in the last year ☐ Yes but in the last year ☐

Has a relative or friend or a doctor been concerned about your drinking or suggested you cut down?
N/A ☐ No ☐ yes, but not in the past year ☐ yes, during the past year ☐

Consuming more than 21 units of alcohol per week for men and 14 for women can damage your health. Ask a doctor or nurse for more advice.

PLEASE MAKE A NEW PATIENT CHECK APPOINTMENT) WITH THE NURSE (you need to bring a urine sample) BEFORE SEEING THE DOCTOR.

PATIENT INFORMATION QUESTIONNAIRE – 0 – 11 years

Including child immunisation form

(Please complete in block capitals as appropriate)

Family Name: ..... **First Name:** .....

Address: .....

Post code: ..... **Date of Birth:** .....

Home telephone: .....

Parent's/carer's name: .....

What is your ethnicity group? Please tick next to the category.

White	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Other ethnic group**
British	White and Black	Indian	Caribbean	Chinese
Irish	Caribbean	Pakistani	African	Vietnamese
Other white – please specify	White and Black African	Bangladeshi	Other Black background	
	White and Asian	Other Asian background		
If none of the above please specify				
Prefer not to state ethnic group ☐				

What is your first language? .....

Any other medical information/medication you feel we need to know about? .....

.....

.....

.....

SALISBURY HOUSE SURGERY, LAKE STREET, LEIGHTON BUZZARD

12 – 15 YEAR OLD

PATIENT INFORMATION QUESTIONNAIRE

You need to complete this form before we can Register you

This form is lengthy but it helps to plan services. All information you provide will be treated in strict confidence and in accordance with all data protection legislation.

PERSONAL DETAILS (Please complete in block capitals as appropriate)

Family Name: ..... **First Name:** .....

Address: .....

Post code: ..... **Date of Birth:** .....

Occupation: .....

Home telephone: ..... **Work telephone:** .....

Mobile telephone: ..... **Email address:** .....
Please indicate (by circling) which number you would prefer us to contact you on during the day

Name of next of kin ..... **Relationship to you:** .....

Next of kin contact telephone: .....

Is your next of kin registered at this practice? **Yes** ☐ **No** ☐

What is your ethnicity group? Please tick next to the category.

White	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Other ethnic group**
British	White and Black	Indian	Caribbean	Chinese
Irish	Caribbean	Pakistani	African	Vietnamese
Other white – please specify	White and Black African	Bangladeshi	Other Black background	
	White and Asian	Other Asian background		
If none of the above please specify				
Prefer not to state ethnic group ☐				

What is your first language? .....

DISABILITY/SPECIAL NEED

Do you have any disability or special need, including visual or hearing impairments? If so, please describe below:

.....

CARER DETAILS

A carer is a person who looks after a relative, friend or child with a physical or learning disability; or who has a mental health problem, a long term illness or who is frail. This definition does not include those who are paid carers.

Are you a carer? **YES ☐** **NO ☐**

Do you have a carer? **YES ☐** **NO ☐**

Your carer's name: .....

Your carer's telephone number: .....

YOUR MEDICAL HISTORY

Do you have any ongoing or significant medical history?

.....

MEDICATION

If you need regular Prescriptions please make an appointment to see a Doctor before your next supply is due. We are unable to issue any Prescription until you have discussed your Medication with a GP.

Do you have any drug allergies: **YES ☐** **NO ☐**

If yes, please list what these are: .....

YOUR HEALTH

Do you drink alcohol? YES ☐ No ☐

What type of alcohol do you drink? .....

How much do you drink each week? .....

Do you smoke cigarettes? YES ☐ No ☐

CONTRACEPTION AND SEXUAL HEALTH

We offer a full range of Contraception Services, including Emergency Contraception (The 'morning after pill') and confidential advice about sexual health matters. Please ask for an appointment with our Practice Nurse. Chlamydia is screened free of charge at the Surgery. Please collect a testing pack from Reception.

Summary Care Records

NHS Bedfordshire

Your emergency care summary

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 should you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

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** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff**.

For more information visit the website **www.nhscarerecords.nhs.uk** or **www.bedfordshire.nhs.uk,** talk to our Patient Advice and Liaison Service (PALS) on 01234 897211, email them at **pals@bedfordshire.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 websites above, requested from PALS or the dedicated NHS Summary Care Record Information Line.

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 it will be assumed that you are happy with these changes and a Summary Care Record will be created 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.

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Dear Patient

ARE YOU CARING FOR SOMEONE?

Do you look after someone who is ill, frail, disabled or mentally ill? If so, you are a Carer. We are interested in identifying carers, especially those people who may be caring without help or support. We know that Carers are often 'hidden' looking after a family member or helping a friend or neighbour with day to day tasks and may not see themselves as a Carer.

We feel that caring for someone is an important and valuable role in the community, which is often a 24-hour job that can be very demanding and isolating for the Carer. We further believe Carers should receive appropriate support by way of access to accurate information on range of topics such as entitlement to benefits and respite care and not least, a listening ear when things get too much.

As a Carer, you are also entitled to have your needs assessed by the Adult Care Services. SA Carer's Assessment is a chance to talk about your needs as a Carer and the possible ways help could be given. It also looks at the needs of the person you care for. This could be separately, or together, depending on the situation. There is no charge for an assessment.

If you are a Carer, this is an opportunity to let the Practice know so that we can update our records and pass your details to the Carers Service who can provide relevant information and advice, Local Support Services, newsletter and telephone Link Line. We can also refer you to Adult Care Services for Carer's Assessment.

Please complete the attached sheet only if you are a Care and return it to the Surgery.

We look forward to hearing from you.

Yours Sincerely,

Zadie Hartwig
Practice Manager

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS Number (if known) .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature .....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:
- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date .....

Ref: 4705