

Dear New Patient

Welcome to Portsdown Group Practice and thank you for choosing to register with us.

Our practice exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website – www.portsdowngrouppractice.co.uk and our practice leaflet (please ask at reception if you would like a leaflet)

As a new patient we would ask that you complete our New Patient Questionnaire fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background. It would be helpful if you could provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). Please note your registration cannot be accepted until the forms are completed in full, with all requested details confirmed. All information provided is treated in the strictest confidence.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or one of the Surgery Team Leaders and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service or fax machine.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully



Carly Darwin
Operations Manager



PORTSDOWN
GROUP PRACTICE

Head Office

Kingston Crescent Surgery
92 Kingston Crescent
North End
Portsmouth
PO2 8AL

Tel No: 02392 009191

PERSONAL DETAILS:	
Title	
Family Name	
Given Name	
Middle Name(s)	
Known As	
Previous Family Name (where applicable)	
Date of Birth	
Town & Country of Birth	
NHS Number	
Gender	
Marital Status	
Ethnicity	<input type="checkbox"/> British <input type="checkbox"/> African <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Caribbean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Irish <input type="checkbox"/> Other White <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Black <input type="checkbox"/> Other Mixed <input type="checkbox"/> White Asian <input type="checkbox"/> Pakistani <input type="checkbox"/> W&B African <input type="checkbox"/> W&B Caribbean <input type="checkbox"/> Refuse to <div style="text-align: right; font-size: small;">Divulge</div>
Main Language	
Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HOME ADDRESS:	
House Name/Flat No.	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Work Telephone	
Mobile Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin	
Relationship	
Telephone Number	
PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:	

Branch Surgeries

Cosham Park House Surgery
Cosham Park House Cosham
Park Avenue
Cosham
PO6 3BG

Crookhorn Surgery
Crookhorn Lane
Waterlooville
PO7 5XP

Heyward Road Surgery
3 Heyward Road
Southsea
PO4 0DY

Paulsgrove Surgery
194 Allaway Avenue
Paulsgrove
PO6 4HJ

Somerstown Health Centre
Tyseley Road
Southsea
PO5 4EZ

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392009191

Website: www.portsdowngrouppractice.co.uk

Email: Portsdown.group@nhs.net



Previous address in the UK			
Name & Address of last GP			
Where were you last treated?		(e.g. GP surgery, walk-in centre, A&E etc)	
IF YOU ARE FROM ABROAD:			
First UK address where registered with a GP			
If previously resident in UK date of leaving;			
Date you first came to live in the UK			
IF YOU ARE RETURNING FROM THE ARMED FORCES:			
Address before enlisting			
Service or Personnel no;			
Enlistment Date		Date of Leaving	
CARERS GROUP:			
If you are a Carer would you like to be added to the Practice's register to receive regular information and meeting dates		<input type="checkbox"/> YES <input type="checkbox"/> NO	
(If yes) I care for (name):			
Relationship to you:			
The person I care for has:		<input type="checkbox"/> Dementia <input type="checkbox"/> Physical Disability <input type="checkbox"/> Mental Illness <input type="checkbox"/> Chronic Disease	
MEDICAL HISTORY:			
Please tick all current or past illnesses/operations including dates where possible:			
<input type="checkbox"/> Heart Disease / Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> COPD	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Dementia	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other (please state):		
Do you have any Allergies?		<input type="checkbox"/> YES - Please state: <input type="checkbox"/> NO	
(e.g. antibiotics, food, bee sting, latex)			
Immunisations; If known, please circle the immunisation received and complete the date if known:			
	Date Received		Date Received
<input type="checkbox"/> Pneumococcal		<input type="checkbox"/> Polio	
<input type="checkbox"/> Tetanus		<input type="checkbox"/> Yellow Fever	
<input type="checkbox"/> Typhoid		<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> MMR	
LADIES: Are you currently Pregnant?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
If you are pregnant please provide estimated delivery date:			

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HEALTH INFORMATION:							
Weight (st/lbs or Kgs)		Height (ft"/ or metres)					
Smoking Status: (please tick one box only)							
<input type="checkbox"/> I am a Smoker							
(For help to stop smoking phone 0800 007 6653 or visit ww.nhs.uk/smokefree)							
<input type="checkbox"/> I have never smoked <input type="checkbox"/> I am an ex-smoker - <u>Date quit:</u>							
Drinking:							
Number of Alcohol units consumed per week;							
Please complete the following questions;							
(Alcohol 'FAST' screening test)						Screening test declined <input type="checkbox"/>	
	Scoring:	0	1	2	3	4	Total
How often do you have 8 (Men) or 6 (Women) or more drinks one occasion?		Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your score is 2,3 or 4:							
How often in the last year have you not been able to remember what happened when drinking the night before?		Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?		Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/clinician been concerned about your drinking/advised you to cut down?		Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Total							
CURRENT MEDICATION:							
If you have a repeat medication slip from your previous GP please attach to this form.							
Electronic Prescription Service:							
The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your new preferred pharmacy:							
PRACTICE SERVICES/GROUPS:							
Would you be interested in joining the Practice Patient Participation Group?				<input type="checkbox"/> YES		<input type="checkbox"/> NO	
Do you wish to register for online services? (e.g. Online prescriptions, online appointment booking, view summary care record)				<input type="checkbox"/> YES		<input type="checkbox"/> NO	
OTHER INFORMATION/PATIENT CONFIRMATION:							
Accessible Information: Please let us know if you would like to receive information from us in an alternative format, e.g. Large Font, Braille, Easy read or audio and we will do our best to accommodate							

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your request.			
<p>Declaration: In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs by the practice. Also by completing and signing this form you are agreeing to abide by the details in the Adam Practice Patient Contract and Zero tolerance Policy (copies of which can be found on the practice website or requested from Reception).</p> <p style="text-align: center;"><u>If any of the details on this form change in the future please inform us.</u></p>			
Signed:		Date:	
<p>Should you require any further information about the Practice please refer to the Practice Website: www.portsdowngrouppractice.co.uk or speak to Reception.</p>			
<p>Data Sharing: some organisations utilise the same clinical system as the practice. By sharing in/out this will enable them to access your medical records, and for us to see a summary of any consultations they have with you immediately. Please see our website or ask Reception for further details if required</p> <p><input type="checkbox"/> I wish to share my data with other organisations who may provide me with medical care</p> <p><input type="checkbox"/> I wish to opt out of data sharing (this means your data will not leave the practice)</p>			
NHS DONOR REGISTRATION:			
<p>I wish to register my details on the NHS Organ donor &/or the NHs Blood Donor register(s) as someone whose organs/tissue may be used for transplantation after my death &/or someone who may be contacted and would be prepared to give blood.</p>			
I would like to donate: (Please tick all boxes that apply)			
<input type="checkbox"/> Any of my organs & tissue or;		<input type="checkbox"/> Any part of my body or;	
<input type="checkbox"/> Heart only	<input type="checkbox"/> Liver only	<input type="checkbox"/> Corneas only	
<input type="checkbox"/> Kidneys only	<input type="checkbox"/> Lungs only	<input type="checkbox"/> Pancreas only	
I would like to join the Blood donor register;		<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have given Blood in the last 3 years;		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature confirming consent/ agreement of items ticked above;			
RECEPTION ONLY:			
Type of ID Seen:	1.	2.	
GP Allocated:	<input type="checkbox"/> YES	<input type="checkbox"/> No	Patient informed: <input type="checkbox"/> YES <input type="checkbox"/> No
PIN document for Online access printed/given to patient			<input type="checkbox"/> YES <input type="checkbox"/> No
Actions completed & ID Seen by (initials):			

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