Cranbrook Medical Practice

**Address: 169 Younghayes Road, Cranbrook, Exeter, Devon. EX5 7DR.**

**Tel: 01404 819207   Fax: 01404 819208**

**Website:** [http://](http://www.cranbrookmedicalcentre.co.uk/)[www.cranbrookmedicalpractice.nhs.uk](http://www.cranbrookmedicalpractice.nhs.uk) **Email:** d-ccg.cranbrookmedicalcentre@nhs.net

GP Partners: Dr Anna Strzeciwilk & Dr Khorsheed Kay

**WELCOME TO CRANBROOK MEDICAL PRACTICE**

The NHS guidelines for new patient registration have been put into place in order to ensure that patient registration fraud within the NHS is minimised. The documents need to be the original copies, and we will take a copy photocopy and give back the originals. In circumstances where a person has only some of or none of the required forms of identity, we can accept a recent photograph signed by the person and a solicitor/police/GP/ magistrate AND a covering letter from the solicitor/police/GP/ magistrate outlining their verification of the person’s identity. When you register with the Cranbrook Medical Practice you will need to provide;

**AN ADULT** (18+ years old):

1. **Photographic Identification:** Valid Driving Licence, Valid Passport, Photo Travel Pass.
2. **Proof of your Address**: Utility/Phone bill within the last 6 months, Bank statement within the last 6 months, National savings bank/post office book, Endowment insurance policies, Building society book, Vehicle registration document, Local authority rent book/card, Council tax documents, Life assurance policies, Mortgage repayment documents

**FOR A BABY/CHILD** (Under 18 years old): A Birth Certificate / Valid Passport

# ‘DID NOT ATTEND’ POLICY - IMPORTANT information – please take time to read

A large number of appointments each month are classified as ‘Did Not Attend’ (DNA) - i.e. the patient did not turn up for the appointment and did not contact the surgery in advance to cancel/change appointment. The effects of these are:

* An increase in the waiting time for appointments for all patients
* Frustration for both staff and patients
* A waste of resources
* A potential risk to the health of the patient

Due to the number of patients failing to attend booked appointments, it may be that you are not able to see the doctor on the day you wish to. In an attempt to try and resolve this and to improve the service to you, the practice has developed the following **Did Not Attend** policy.

**PLEASE HELP US TO HELP YOU**: Our patients know it can sometimes be difficult to get a routine appointment with a GP or nurse. In the course of events where demand is unpredictable, that cannot easily be remedied. One thing that makes this more difficult to overcome is the problem of missed appointments – DNA’s. Where patients have been declined appointments because the consultations are fully booked, it is at best disappointing when one of those booked appointments does not turn up and has not contacted the practice to cancel the appointment so that it can be released for others or telephones so late as to make it impossible to allocate to another patient. Remember that your DNA is other patient’s denied appointment. If you cannot attend your appointments please let us know as soon as possible. We can offer the appointment to someone else and alternative appointment to you.

**MISSED APPOINTMENTS**: If you fail to attend a pre-booked appointment, an informal warning letter will be sent to you requesting a specific reason preventing you from attending and not informing us when you cannot attend. This letter will also advise of the process and importance for cancelling appointments you are unable to attend. Should you fail to attend a second appointment following receipt of the first letter, a formal letter will be sent informing you that a further occurrence could risk removal from the practice. **If you DNA (did not attend) more than 3 (three) occasions** in the space of 12 months, a formal letter will be issued to inform you that you will be removed from the practice and will need to find an alternative GP practice. This is in the interest of patient care, being able to assist patients in need of appointments, especially with urgent needs or emergencies. Warning letters are valid for a period of 12 months.

**New Patient Questionnaire**

Welcome to our Practice and thank you for choosing to register with us. We would be grateful if you could complete this form to enable us to provide you with better care.

**Your Named & Registered GPs for Cranbrook Medical Practice: Dr A Strzecwilk and Dr K Kay**

**PERSONAL CONTACT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Title** | **First Name** | **Surname** | **Date of Birth** |  |
| **Please tick box if over 75** [ ]  |
| **Parent(s) Name(s) (Under 16s Only):****Are they registered with any of our practices? Yes [ ]  No [ ]**  |
| **Address & Postcode** |  |
| **Contact Numbers:** | **Home Phone:**…………………………………………………**Mobile:**…………………………………………………… The practice send text messages to remind you of appointments and may contact you via text with updates or promoting health services at the surgery. **The practice requires express consent for this so please tick yes to opt in or no to opt out**. **Yes [ ]  No [ ]**  |
| **Email Address** | **Email:**  ……………………………………………………………………………………………………………………………………………..Your email address will be used for our Online Appointment Booking and Prescription Ordering services and updates or promoting health services at the surgery. **The practices require express consent for this so please tick yes to opt in or no to opt out**. **Yes [ ]  No [ ]**  |
| **Contact preferences** | **I prefer to be contacted by: SMS [ ]  Email [ ]  Telephone [ ]  Letter [ ]**  |
| **Next of Kin** | **Name: Contact Number:****Relationship:****Is this person registered with any of our practices? Yes [ ]  No [ ]** *In the event of an emergency, it is useful for us to have details of your next of kin and a contact telephone number.*  |
| **Carer/ Cared For Information** | **Are you a Carer? Yes** **[ ]  No** **[ ]** (Do you provide, without payment, help and support to a relative, friend or neighbour, who could not manage to stay at home without your help due to age, sickness or disability.) **Are you cared for by a relative, friend or neighbour?**  **Yes [ ]  No [ ]** If Yes to either of the above, please indicate whom you care for/receive care from:**Name:****Is this person registered with any of our practices? Yes [ ]  No [ ]**  |
| **Please nominate which pharmacy you would like to use for any current or future medications: ......................................................…………………………………………………………………………………………………….****Repeat Medication**: Do you have any medication on a repeat prescription? **Yes [ ]  No [ ]** **If Yes, please attach your repeat medication slip to this form.** ***Please note that it is your responsibility to inform us of any changes to your Personal Contact Information*** |
| **Personal Confidential Data Consent**Are you happy for the practice to share your information with other clinicians involved in your care? **(Sharing OUT) Yes [ ]  No [ ]** Are you happy for other clinicians involved in your care to share your information with the practice? **(Sharing IN) Yes [ ]  No [ ]** **NHS Summary Care Record**A Summary Care Record (SCR) is **a** **summary of key health information (Medication, Allergies & Adverse Reactions),** which can only be accessed by NHS healthcare staff outside your GP surgery caring for you in an emergency. **Website:** <http://systems.hscic.gov.uk/scr/patients> The practice requires express consent for this so please tick yes to opt in or no to opt out. **Yes [ ]  No [ ]** **The Health & Social Care Information Centre (HSCIC) [Care.data programme]**The Care.data programme will bring together securely health & social care information from different settings in order to see what’s working really well in the NHS and what could be improved. This is not accessible to clinicians and will not help with your care. This is for statistical purposes only.   The practice requires express consent for this so please tick yes to opt in or no to opt out. **Yes [ ]  No [ ]**  |

**Ethnic Origin**

White British [ ]  White Irish [ ]  White Other [ ]  Indian [ ]

Bangladeshi [ ]  Asian Other [ ]  Mixed Caribbean [ ]  Mixed African [ ]

Mixed Asian [ ]  Mixed Other [ ]  Black Caribbean [ ]  Black African [ ]

Black Other [ ]  Chinese [ ]  Do not wish to disclose [ ]  Other [ ]

**Please state your first language:**

**Is a translator required for Appointments? Yes** **[ ]  No** **[ ]**

**CLINICAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Height |  | Weight |  |

**Long Term Conditions & Communication Needs**

Please indicate if you have any of the following long term conditions or communication needs? Please tick 🗹

**All patients who register with the practice will require a new patient appointment.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** |  | **Age/Date of Diagnosis** | **Condition** |  | **Age/Date of Diagnosis** |
| Asthma  | [ ]  |  | Drug/Alcohol Dependency | [ ]  |  |
| Autism/Aspergers | [ ]  |  | Epilepsy | [ ]  |  |
| Blind or Visual Impairment | [ ]  |  | High Blood Pressure /Hypertension | [ ]  |  |
| Cancer | [ ]  |  | Learning/Literacy Difficulties | [ ]  |  |
| Chronic Kidney Disease | [ ]  |  | Low Blood Pressure/Hypotension | [ ]  |  |
| COPD  | [ ]  |  | Post-stroke difficulties | [ ]  |  |
| Coronary Heart Disease | [ ]  |  | Stroke or Mini-Stroke/TIA | [ ]  |  |
| d/Deaf or Hearing Loss | [ ]  |  | Thyroid Disease (on thyroxine) | [ ]  |  |
| Dementia | [ ]  |  | **Contraception** (Pill/Depo Injection/Patch/Coil) | [ ]  | Next Due: |
| Depression/Mental Health  | [ ]  |  | **Other:** | [ ]  |  |
| Diabetes Type 1  | [ ]  |  | **Other:** | [ ]  |  |
| Diabetes Type 2  | [ ]  |  | **Other:** | [ ]  |  |
| **Accessible Information Standards (SCCI 1605 Accessible Information)**The practice wish to understand and record any particular communication needs you might have. The will then do their best to meet your needs in all contacts with the Practice. Is your communication with others affected by a health problem or disability that has lasted, or is expected to last, at least 12 months? **Yes [ ]  No [ ]** **If Yes please give details:…………………………………………………………………………………………………………………….**Please indicate if any of the following information and communication preferences would help improve your access:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Large Print | [ ]  Braille | [ ]  Audio | [ ]  Text-to-speech |
| [ ] Telephone Communication | [ ]  Easy-read | [ ]  Makaton | [ ]  Advocate/Carer |
| [ ]  Other: |

 |
| **Safeguarding (Children & Adults)**Are you, or have you been, part of any Safeguarding investigation? **Yes [ ]  No [ ]**  |

**Allergies** Do you have any known allergies? **Yes [ ]  No [ ]**

*If Yes please provide details: ………………………………………………………………***………………………………………………..**

**Smoking (Excludes Children)** Please indicate your current smoking status:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Non Smoker** | **Current Smoker** | [ ]  | **Ex Smoker** | [ ]  |
| Non-smoker & Never smoked [ ]  | Please indicate how many you smoke, on average, per day? |  | Please indicate how many you used to smoke, on average, per day? |  |
| Do any of the following apply? Cigar Smoker [ ]  Pipe smoker [ ]  Rolls own cigarettes [ ]  Vapour [ ]  |
|  |

**Do you know that stopping smoking is the best thing you can do to improve your health?**

**Please ask for an appointment with one of our team if you would like support to quit smoking.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Alcohol Use (Excludes Children)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Less Than Monthly** | **Monthly** | **Weekly** | **Daily/****Almost Daily** |
| **MEN:** How often do you have 8 or more drinks on one occasion |  |  |  |  |  |
| **WOMEN:** How often do you have 6 or more drinks on one occasion |  |  |  |  |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? |  |  |  |  |  |
| How often during the last year have you failed to do what was normally expected of you because of drinking? |  |  |  |  |  |
| In the last year has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down? | **No** **[ ]**  | **Yes, on one occasion** **[ ]**  | **Yes, on more than one occasion** **[ ]**  |

 |

**Signed:…………………………………………………….PRINT NAME:………………………………………………………**

**Thank you for taking the time to complete the New Patient Health Questionnaire**

  **APPLICATION FOR ONLINE ACCESS TO MY MEDICAL RECORD**

**By completing this document you are giving explicit consent for the surgery to register your details for you to have access to your information online.**

|  |  |
| --- | --- |
| Surname | Date of Birth |
| First Name |
| AddressPostcode |
| E.mail address |
| Telephone number | Mobile number |

 I would like access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | □ |
| 1. I will be responsible for the security of the information that I see or download
 | □ |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | □ |
| 1. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible
 | □ |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 | □ |
| 1. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible
 | □ |

|  |  |
| --- | --- |
| Signature | Date |

 **For Practice use only**

|  |  |
| --- | --- |
| Patient NHS number |  |
| Identity verified by (initials) | Date | MethodVouching □Vouching with information in record □Photo ID and proof of residence □ |
| Authorised by | Date |
| Level of record access enabledAll □Prospective □Retrospective □Detailed Coded Record □Limited parts □ | Notes/explanation |

**Cranbrook Patient Participation Group (PPG)**

**needs your help**

**Did you know that:** All patients registered with the Cranbrook Medical Practice automatically become members of the PPG?

Information on PPG progress will be available within the next few weeks on both the Practice website and NHS Choices. In the meantime visit our website for further information:

D-CCG.CranbrookMedicalCentre@nhs.net

The PPG Committee along with the Practice progress issues affecting services provided to patients and therefore we need to obtain patients views.

**How can you help?**

We are about to establish a consultation group of those registered with the Practice and we are asking for your help.

We would be grateful if you would agree to share your email address with the PPG so that we can make contact to ask for your views as required.

Please complete the following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ /\_\_\_\_\_\_/\_\_\_\_\_\_\_

I agree to become a Member of the PPG Consultation Group Yes No

If you answered yes, then please provide an email address:

**Thank you. You will receive acknowledgement of receipt of this form by the Chair of the PPG Ray Bloxham**