The Surgery
Amersham Health Centre
Chiltern Avenue, Amersham, Bucks HP6 5AY
Tel 01494 434344 : Fax 01494 733711

Dear Patient

Thank you for your request to join The Surgery at Amersham Health Centre. We look forward to offering you the highest standards of care.

All new patients are asked to provide proof of identification (children registering with their family do not have to do this). Please will you bring in your passport as proof of identity when returning your registration forms. If you do not have a passport, please will you bring in your birth certificate. Please let us know if you cannot supply either document.

Proof of address is also required before we can register you. Please can you supply a document such as a utility bill, council tax bill or bank statement that contains your name and address.

Non-British citizens will also need to provide proof of entitlement to free NHS treatment. This can be a European Health Insurance Card or a current residence permit in addition to a passport.

A copy of the Patient/Practice Agreement is enclosed for you to retain. Please confirm your acceptance of the terms of this agreement by signing below. Thank you.

Yours sincerely

Mr Alan Sykes
Practice Manager

……

I have read and agree to the terms of the attached Patient/Practice Agreement. I have retained a copy of this agreement.

Name:	
Date of Birth	
Signature	
Date	

……

Practice Admin use only:

		Initials
Date Identification seen		
Type of identification seen	*British Passport YES / NO* *Passport from (name of country)* …….. *Or Birth certificate from: ……*	
Document type seen as proof of address		
Non EC citizens Residence Permit (Visa) Expiry date:		
Yellow Flag on Computer (date)		
Notes		

The Surgery

Amersham Health Centre

The Practice's Commitment

MISSION STATEMENT

We, the Practice, aim to provide our patients with the highest quality of health care available under the National Health Service, delivered by a well trained and motivated primary health care team. The special skills of every team member will be used to the benefit of our patients.

PRACTICE PRINCIPLES

We aim to care for our patients according to the highest professional standards and you will be treated with courtesy and consideration by all our staff. You will receive appropriate information about your conditions and treatments and will be educated in health care matters whenever possible. Our doctors, nurses and staff will take part in continuing training and professional development.

CONTINUITY OF CARE

We will try to offer an appointment with the doctor of your choice whenever possible. As the doctors work as a team, if you have a problem that cannot wait it is much better to book an appointment with another doctor rather than to wait for the doctor of your choice.

APPOINTMENTS

The doctors and nurses will try to see you at your appointment time but may ask you to come back for another appointment if your problem takes longer than the time you have booked. If you have complex problems to discuss you can ask for a double appointment when you contact reception.

CONFIDENTIALITY

All information relating to a patient will be held confidentially and will not be released without the patient's written consent.

POLICY ON SEEING MINORS

All children under the age of 12 must be accompanied by an adult throughout the consultation and examination. Young people between the ages of 12 and 14 can consult alone but must attend the surgery accompanied by a responsible adult whose permission and co-operation will be sought. 14 to 16 year olds may attend un-accompanied and consult alone. Any patient over the age of 16 has the right to have test results given only to them and results will only be given to a parent if it is clearly recorded in the patient notes that permission has been given for that episode of care.

CHAPERONES

A chaperone is available for any consultation at any stage. This can be requested via the reception staff or any clinical staff member.

COMPLAINTS

The Practice agrees to take all complaints seriously and will reply in writing as soon as possible.

The Patient's Commitment

DISCLOSURE

I, the patient, agree to disclose all material facts regarding my health to my General Practitioner and his or her clinical staff.

APPOINTMENTS

I agree to try to attend on time for all appointments booked with the practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to re-book for another time.

EMERGENCY APPOINTMENTS

I agree only to use these appointments for medical emergencies that require immediate treatment.

HOME VISITS

I shall request a home visit from the practice only if I cannot physically attend at the practice.

PHONING BEFORE 11:00 A.M. MAKES IT MUCH EASIER FOR THE PRACTICE TO MANAGE THESE REQUESTS.

TREATMENT OF STAFF

I agree with the policy of zero tolerance of abuse towards all NHS Staff. I agree not to behave in an abusive, threatening or otherwise aggressive manner with any member of the practice staff. I acknowledge the right of the practice to remove me from their list without appeal should I behave in a manner that is prohibited.

REPEAT PRESCRIPTIONS

When I need to request repeat prescriptions, I agree to give the practice at least two working days notice of my need for more medication. Furthermore I agree to make my request either in person, by fax, post, via our website (amershamhealthcentre.co.uk) or on the slip provided (we cannot accept telephone requests for repeat prescriptions). I agree that:

- I will not keep more than two months' supply of pills or other items in my home.
- I will not order medication more than two weeks before it is needed.
- I will not stockpile any items.
- I will not order every item on my repeat list for convenience but will order only what I really need.

MOBILE PHONES

I agree to switch off my mobile phone before I start my consultation with the doctor or nurse. I agree to switch it off immediately should it ring while I am with the doctor or nurse if I have forgotten to turn it off.

PRIVATE FEES

We are often asked to write letters and complete forms on behalf of patients. This work is not covered under the NHS and a charge will be made. Examples are given below. Please contact the surgery for an up to date price before making your request. Payment will be requested in advance before any private work is carried out.

- Private prescriptions for travelling abroad
- Unfit to sit examination letter
- Holiday cancellation form
- Sickness / accident benefit and insurance forms
- Fitness to travel / perform / exercise letter
- Letter regarding medication for holidays
- Passport forms
- Freedom from infection certificate
- Medicals
- Private medical certificate
- Private vaccinations
- Private reports

THANK YOU FOR READING AND SIGNING THIS AGREEMENT

Amersham Health Centre
NEW PATIENT QUESTIONNAIRE

Welcome to Amersham Health Centre. It often takes several weeks for your records to reach us from your previous doctor. Answering these questions will help us during this time. The information will be handled confidentially but if you are concerned about any of the questions leave them blank. Please return the completed questionnaire to the receptionist.

TODAY'S DATE .....

ARE YOU CURRENTLY REGISTERED WITH A LOCAL GP SURGERY	**YES / NO**
If so, please state the name of the surgery	
Why do you want to change your GP surgery?	
Are any other members of your household already registered with a Doctor in this Surgery?	**YES / NO**
If YES, please enter their names.	
Have you ever seen a doctor at this Surgery in the past?	**YES / NO**

YOUR DETAILS:

Name:			MALE / FEMALE Please circle
Address:			
Date of Birth		Place of Birth	
Postcode			
Home Telephone Number			
Mobile Telephone Number			
*Please tick the box if you **don't** want to receive future text messages or reminders for appointments*			
Occupation:			
E-mail Address			

In a medical emergency who should we contact on your behalf:			
Name			
Address			
Home Telephone Number		Relationship to you	
Mobile Number			

Please help us update your HEALTH Records:				
1	Your Height	**2**	Your Weight	
3	Your waist measurement (if known)	cm **OR** inches		
4	Do you smoke?	YES / NO		
	If Yes, how many per day?	Cigarettes / Cigars per day:		
	Date started / age when started.			
	If an ex-smoker, when did you stop?	Year stopped:		
	We strongly advise all smokers to stop smoking**. **We run a Smoking Cessation Clinic - please enquire at reception if you require more information.			
5	Do you exercise? If yes, how much?	YES / NO Gentle / Moderate / Vigorous		
6	Do you follow a special diet? If yes, what type of diet?	YES / NO Diabetic / Low Fat / High Fibre / Low Salt		
7	**Do you have a family history (father or brother under 55 years / mother or sister under 65 years) of**			
	Heart disease	YES / NO	Diabetes	YES / NO
	Stroke	YES / NO	Cancer	YES / NO
	Raised Blood Pressure	YES / NO		
8	Please detail any allergies you may have to medicines or foods.			

9	**If over 65yrs**: Have you had a fall in the last 6 months?	YES / NO
	If YES *Please ask for a leaflet about falls prevention at Reception*	

	Female patients only:	
10	Do you have a contraceptive coil fitted? If so, do you know the type of coil? Do you know when was it fitted?	YES / NO Mirena / Copper coil / Don't know Yes – date: No
11	Do you have a contraceptive implant? If so, do you know when was it fitted?	YES / NO Yes – date: No
If you are a woman between the ages of 16 and 40 years it is important for you to know if you have immunity against Rubella (German measles). Please ask your doctor or practice nurse for full information.		

<u>Are you Caring for Someone or does Someone Care for You</u>?
A Carer is a person who is looking after or is responsible for the care of a relative, friend or neighbour who is mentally or physically disabled or whose health is impaired by old age.

Do You have a Carer? YES / NO			**Do You Care for Someone Else Who Can't Manage Without You? YES / NO**
If Yes, please give details about your carer:			If Yes, please give details about the person you care for:
Name:			
Address:			
Telephone Number:			
Relationship to you:			
Please can we pass your carer details to Carers Bucks			YES / NO

To which of these ethnic groups do you feel you belong:

Please tick the box that applies to you.

White British		Indian/British Indian		White and Black Caribbean	
Any other white background - please specify:		Pakistani/British Pakistani		White and Black African	
Black Caribbean / British Caribbean		Bangladeshi / British Bangladeshi		White and Asian	
Black African / British African		Any other Asian background – please specify:		Any other mixed background – please specify:	
Any other black background – please specify:		Chinese		Other – please specify:	
I DO NOT WISH TO ANSWER		**Please state your first language**			
Do you need an interpreter?	Yes / No				

ELECTRONIC PRESCRIPTIONS

If you have recently moved to the Amersham area and had nominated a pharmacy for your electronic prescriptions near your previous home, please confirm that you wish to cancel that nomination.
If you do not cancel the nomination, all your prescriptions will continue to go to that pharmacy.

Please cancel the pharmacy nomination from my previous address	***YES / NO***

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.

For more information visit the website **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020. If you choose not to have a Summary Care Record, you can let us know at any time if you change your mind.

We are supporting Summary Care Records and as a patient you have a choice:

Yes I would like a Summary Care Record - please tick this box and a Summary Care Record will be created for you.	
No I do not want a Summary Care Record – please tick this box if you do not want a Summary Care Record.	

Your Name	
Your Signature	
Date	

My Care Record – your local emergency care summary

My Care Record is similar to the Summary Care Record but the My Care Record will only be available to authorised health and social care staff locally, and they will ask your permission before they look at it.

We are supporting Summary Care Records and as a patient you have a choice:

Yes I would like a My Care Record - please tick this box .	
No I do not want a My Care Record – please tick this box if you do not want a My Care Record.	

Your Name	
Your Signature	
Date	

CONFIDENTIALITY OF HEALTH RECORDS

(As per the Caldicott Committee Report on review of Patient Identifiable Information, published in December 1997)

We ask you for information so that you can receive proper treatment. We keep this information, together with details of your care, because it may be needed if we see you again. Sometimes the law requires us to pass on information, for example, to notify a birth. The NHS Central Register for England & Wales contains basic personal details of all patients registered with a General Practitioner. The Register does not contain clinical information. You have a right of access to your health records.

EVERYONE WORKING FOR THE NHS HAS A LEGAL DUTY TO KEEP INFORMATION ABOUT YOU CONFIDENTIAL.

You may be receiving care from other people as well as the NHS, so that we can work together for your benefit we may need to share some information about you. We only ever use or pass information about you if people have genuine need for it in both your and everyone's interests. Whenever we can, we shall remove details, which identify you as an individual. Anyone who receives information from us is also under legal duty to keep it confidential. We ensure that we have your written consent when passing medical information to non-medical persons, e.g. solicitor, insurance companies etc.

THE MAIN REASONS FOR WHICH YOUR INFORMATION MAY BE NEEDED ARE:

- Giving you health care and treatment.
- Looking after the health of the general public.
- Managing and planning the NHS, for example: Making sure that our services can meet patient needs in the future, auditing clinical records, preparing statistics on NHS performance and activity, Investigating complaints or legal claims
- Helping staff to review the care they provide to make sure it's of the highest standard.
- Training and educating staff (but you can choose whether or not to be involved personally).
- Research approved by the local Research Ethics Committee. (If anything to do with the research would involve you personally, you will be contacted to see if you are willing to be involved first).

Please indicate below whether you are willing for your records to be reviewed by an Authorised person, as appropriate.

I am willing*/not willing* for my records to be reviewed by an Authorised person.

I understand that no information will be divulged to anyone else. (* Delete as appropriate)

Name (please use capitals):	Date of Birth:
Signed:	Date:

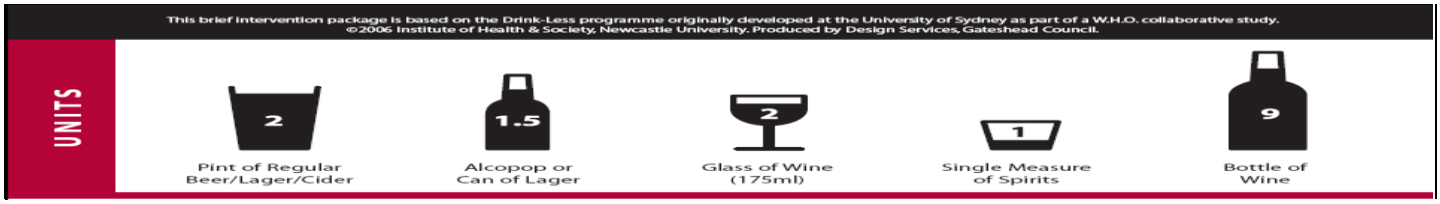
Alcohol Consumption

Name (please use capitals):	Date of Birth:
Do you drink alcohol?	YES / NO / NEVER
If **Yes**: Weekly Alcohol Consumption	…… Units per week
If **No**, have you drunk in the past? If so, how much in an average week?	…… Units per week. Date stopped drinking: ……..

Fast Alcohol Screening Test (FAST)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men)/ 6 (women) or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
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/ doctor/ health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

If your score is 3 or more please complete the Alcohol Users Audit Questionnaire below.



Alcohol Users Audit Questionnaire

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard units do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
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	
Have you or someone else been injured as a result of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

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VOS – Patient Disclaimer / Information Sheet

This policy is intended to provide you (the patient) with all the information you need to know about Vision Online Services (VOS). It covers how your information is stored, how it is accessed, and patient confidentiality.

Vision Online Services (VOS) is provided to you by our clinical provider INPS. This is a free service, funded by the NHS, to give patients online access to booking appointments and ordering repeat prescriptions.
Information Security:-

All information you provide to us is stored on our clinical providers secure servers. During registration, you will be asked to set up your own password to access this service. It is your responsibility to keep this password safe and confidential. Only you can access your own account unless you have registered children aged 14 and below.

The internet is not a secure place; however, our clinical provider INPS have gone to great steps in making sure your information is secure as possible. See privacy policy here https://www.myvisiononline.co.uk/vpp/

Registering to use VOS:-
If you are aged 15 and over, you may register to use our Vision Online Services. You can only register yourself and must show at least one proof of identity, i.e. passport, driver's license or utility bill (if you are aged 15 to 18, we will also accept a young person's bus pass or library card). You must have an email address to register for VOS otherwise you can NOT use this service.

Registering someone else 15 and above:-
Unfortunately, you can NOT register another person who is 15 and above to use Vision Online Services. Each patient wishing to register to use VOS will need to show their own ID and supply their own email address. Exceptions are given where a patient is housebound and unable to visit the practice.

Registering Children 14 and below:-
Parents or legal guardians may register children aged 14 and below. Again, you will have to show proof of identity – your own, not your child's.

Access to children's / young adults account(s) when they turn 15 and above:-
Once a child, whose VOS account you have previously had access to, turns 15, access to their account by you or anyone else is prohibited. Please ask the child / young adult to visit the practice and register their own account to use VOS. Please note that they will need to bring in proof of identity, as specified above, and supply their own email address.

Missing 4 or more appointments within 12 months:-
If you have missed 4 or more appointments within 12 months which were booked but not cancelled, your Vision Online Services account will automatically be disabled and you will not be able to access it. You can request to be set back up if you have not missed any subsequent appointments from the date your account was disabled. If you continue to miss appointments, we may disable your VOS account indefinitely.

I hereby agree to and understand the above information and consent to registering myself and / or my child aged 14 and below to use Vision Online Services. I understand that if I have registered a child aged 14 and below that when they turn 15, myself and anyone else, is prohibited to use their account and I must inform the child, if they wish to use this service, that they must visit the practice and register their own account as stated above. I also understand that missing 4 or more appointments which haven't been cancelled will mean my VOS account will be disabled for 6 months pending a review.

Print Name: _____ Signed: _____ Date: _____

AMERSHAM HEALTH CENTRE ONLINE SERVICES

We now offer our patients additional services which you may want to sign up for if you haven't done so already. Please fill in the forms below and hand back to reception.

- First Name: _____
- Last Name: _____
- Date of Birth: _____

You can now book your appointment and order your repeat prescriptions online from your computer using our new Vision Online Services (VOS).

Proof of identification required. Please complete this form, hand it back to reception and provide us with one of the following proofs of ID: passport, drivers licence or utility bill.

I would like to sign up to Vision Online Services

E-mail Address - PLEASE PRINT

_____

For office use: Proof of Identity seen: Passport ☐ *Driving Licence* ☐ *Utility bill* ☐ *Initials:* _____

Free Appointment Reminder Service

As an additional service to our patients', we now offer a free appointment reminder service via text messaging. If you would like to opt out of this service, please tick the box at the bottom. We strongly recommend that you use this free service.

For our records, can you please provide us with your mobile phone number even if you choose to opt out of this free service so that we can update our records.

Mobile Phone Update:

* Mobile Number: _____

Opt out: I would NOT like to receive appointment reminders ☐

Electronic Prescription Service

We can send completed prescriptions electronically direct to the pharmacy of your choice. All your prescriptions will be required to go to this pharmacy. If you would also like to use this service, please speak to your pharmacist. Alternatively, nominate the pharmacy of your choice below and ask for a copy of the letter 'A new way to get your medicines.' For more detailed information visit www.hscic.gov.uk/epspatients

Name and address of nominated pharmacy:

_____

_____

For office use: copy of letter 'A new way to get your medicines' given to patient ☐