

# **RYDINGS HALL SURGERY**

## **NEW PATIENT REGISTRATION PACK**



**Church Lane  
Brighouse  
HD6 1AT**

**Tel: 01484 715324**

**[www.rydingshallsurgery.org.uk](http://www.rydingshallsurgery.org.uk)**

**PLEASE READ AND KEEP PAGES 1 – 4 FOR YOUR REFERENCE**

**COMPLETE AND SIGN PAGES 5 – 11 AND PRESENT ALONG WITH 1 FORM OF PHOTOGRAPHIC ID AND 1 PROOF OF ADDRESS FROM THE LIST DETAILED ON PAGE 2.**

**IF REGISTERING A CHILD UNDER 5 YOU MUST BRING YOUR RED BOOK DETAILING IMMUNISATIONS GIVEN.**

**THE PRACTICE WILL THEN PROCESS YOUR REQUEST.  
PLEASE CONTACT US AFTER TWO WORKING DAYS TO CONFIRM YOUR REGISTRATION.**

**THANK YOU**

## **New Patient Registration - A Reference Guide for Patients**

If you live within our practice boundary, you can register with the practice, whenever our list is open. You can find out more about our practice before registering by going to [www.rydingshallsurgery.org.uk](http://www.rydingshallsurgery.org.uk). You can also go to [www.nhs.uk](http://www.nhs.uk) and navigate to "services near you"/GP putting in your post code to find us.

In order to register with us all patients will be asked to provide proof of identity and address to enable us to assess you as 'ordinarily resident'. Please see below for acceptable documents, and bring them with you when you return the registration pack.

### **\*ONLY ONE FROM EACH SECTION IS REQUIRED**

PHOTOGRAPHIC ID, a current passport, driving licence, a current EU national identity card, Blue disabled parking permit (photo version only), police warrant card or armed forces ID card,

PROOF OF ADDRESS, P.A.Y.E coding notice form HMRC, benefit letter/Pension letter, this must be for the current tax year, a current valid driving licence (if not already produced as identification), a utility bill dated within the last 3 months (NOT MOBILE PHONE), a council tax bill for the current tax year.

Please note: if you have a UK photo card driving licence this will count as **both** photo ID and proof of address verification. If under the age of 16 and born in the UK or over 16 with no available photographic ID, please provide a birth certificate. However this will mean that you will not be able to have full online access to medical records.

**Repeat Medication:** please ensure that you have an adequate supply of your repeat medications from your last GP as you may not be able to order them from us at short notice whilst we are processing your application. (You can order medication or book appointments with your previous GP for up to 30 days after leaving the area to give you time to get registered elsewhere.) Please bring with you when you return the registration pack a current GP prescription counterfoil or recent hospital discharge letter showing your repeat medication.

**If REGISTERING A CHILD UNDER 5 YOU MUST BRING YOUR RED BOOK DETAILING IMMUNISATIONS GIVEN.**

**Your named GP is:** \_\_\_\_\_ For more information about this please refer to the practice leaflet given with this form.

### **New Patient Registration Checks**

New patients who register with the Practice are entitled to a health screen with our Assistant Practitioner and we would encourage you to do this as it helps us to assess and review your health care needs and record clinical data such as height, weight, blood pressure etc. This will also offer you the opportunity to discuss particular health issues you may have. The appointment will enable you to familiarise yourself with the Practice and the services we provide. You will also be directed to our website and / or provided with literature which outlines how the Practice operates.

Once we receive your medical records they are electronically summarised in our clinical system within eight weeks.

If you see our Assistant Practitioner for a New Patient Health Check. They will ask about:

- current and past illnesses and operations
- illnesses that run in the family
- medication and allergies
- any screening tests such as cervical smears
- any immunisations such as tetanus.

They will check your blood pressure, weight, and height and test a sample of your urine.

You are also offered advice on:

- healthy eating
- exercise

- sensible limits for alcohol
- how to stop smoking (if appropriate).

They will assess your risk of heart disease and can arrange a cholesterol check, if appropriate and if you are on regular medication you should book an appointment with a GP or Advanced Practitioner.

**YOU MUST ATTEND FOR YOUR NEW PATIENT CHECK TO ENABLE US TO RECORD ACCURATE AND UP TO DATE MEDICAL INFORMATION ON YOUR MEDICAL RECORDS.**

**Text Messages**

Appointment reminders will automatically be sent to you by text message if we have your mobile number (unless you have opted out of this service). Please **do not** rely on the text reminders as there can be technical problems from time to time so we would recommend you also making a note of any appointments booked with us.

**PLEASE MAKE SURE WE HAVE YOUR UP TO DATE MOBILE NUMBER. LET US KNOW IF IT CHANGES.**

You can visit our website for further information: [www.rydingshallsurgery.org.uk](http://www.rydingshallsurgery.org.uk)

**Online Services**

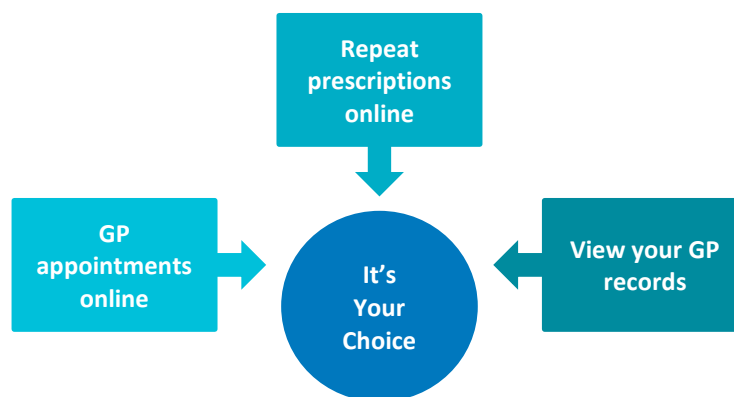
Patients can now book/cancel appointments, order/track repeat prescription requests and view medical records online. You can register via our website. User IDs and passwords can be reset online if you have forgotten your details. You will need to visit the practice to verify ID before full access can be activated. Please complete the form attached to request access to these services.

**Online Services Records Access  
Patient information leaflet 'It's your choice'**

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.



It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

## Before you apply for online access to your record, there are some other things to consider.

### *Things to consider*

#### **Forgotten history**

There may be something you have forgotten about in your record that you might find upsetting.

#### **Abnormal results or bad news**

If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

Choosing to share your information with someone

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

#### **Coercion**

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

#### **Misunderstood information**

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

#### **Information about someone else**

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:

Keeping your online health and social care records safe and secure

<http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf>

**Named GP = Dr**

## RYDINGS HALL SURGERY

### Patient's details (Please complete in BLOCK CAPITALS and delete/tick as appropriate)

Mr / Mrs / Miss / Ms Surname ..... First names .....

Date of birth .... / .... / .... Place of birth: .....

Previous surname ..... (if appropriate)

NHS No ..... / ..... / ..... / ..... / ..... / ..... / ..... / ..... / ..... / ..... Male / Female (delete as appropriate)

Home address .....

..... Postcode .....

Telephone number ..... Mobile Number .....

Please tick if you **DO NOT** wish to receive appointment reminders or test results by text   
**(leave blank if happy to receive texts).**

Email address ..... @ .....

Please tick if you **DO NOT** wish to be contacted via email  (leave blank if happy to receive emails).

**If you are registering a child under 5:** I wish the child above to be registered with the doctor and agree to engage with the Childhood Vaccination Programme vaccination against communicable diseases.

### Please ask for further information on this programme if you do not understand the question.

Your previous address in UK: Name and Practice/address of previous doctor

.....

.....

.....

Postcode ..... Postcode .....

**We may use this information to contact your previous surgery to confirm that the information you have provided is correct.**

If you are from abroad (Your first UK address where registered with a GP)

Address .....

..... Postcode .....

If previously resident in UK, date of leaving: .... / .... / .....

Date you first came to live in UK: ..... / ..... / .....

If you are returning from the Armed Forces please provide your address before enlisting:

Address .....

..... Postcode .....

Service or personnel number ..... Enlistment date ..... / ..... / .....

## SUPPLEMENTARY QUESTIONS

### PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the visitor and migrant patient leaflet, available from your GP practice.

**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP Practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment. The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS Secondary care organisations (e.g. hospitals) and NHS digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.**

#### Please tick one of the following boxes:

- a)  I understand that I may need to pay for NHS treatment outside of the GP Practice
- b)  I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIS, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested.
- c)  I do not know my chargeable status


I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

#### A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	
Print name:		Relationship to patient:	
On behalf of			

**Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.**

### NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS AND S1 FORMS

Do you have a non-UK EHIC or PRC?	<input type="checkbox"/> Yes / <input type="checkbox"/> No	If yes, please enter details from your EHIC or PRC below:
 <p><i>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC)/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at hospital.</i></p>	Country Code	
	3: Name	
	4: Given Names	
	5: Date of Birth	
	6: Personal Identification Number of the card	
	7: Identification number of the institution	
8: Identification number of the card		
9: Expiry date		
PRC validity period (a) form:		(b) To:

Please tick  if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

**How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS digital solely for the purposes of cost and recovery. Your clinical data will not be shared in the cost recovery process. Your EHIC, PRC or S1 information will be shared The Department of Work and Pensions for the purpose of recovering costs from your home country

**Ethnicity:** The collection of this data is in accordance with the legislation contained in the Race Relations Act and follows the recommendations of the Commission for Racial Equality (CRE). The

categories of race origin listed below follow the recommended categories for public bodies in England and Wales, and are consistent with the presentation and collection of ethnicity detail within the 2001 Census. Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

**Choose ONE section from A to E, and then tick ONE box to indicate your background.**

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please write in below
<input type="checkbox"/>	

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please write below
<input type="checkbox"/>	

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please write below
<input type="checkbox"/>	

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other black background please write below
<input type="checkbox"/>	

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other please write below
<input type="checkbox"/>	

Do you speak English? Yes/No (please delete as appropriate) Do you require an interpreter? Y  N

What is your first language if it is not English?.....

**NHS Organ Donor Registration:** I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

**PLEASE TICK AS APPROPRIATE:**  kidneys  heart  Liver  Corneas  Lungs  Pancreas  Any part of my body

Signature confirming consent to organ donation ..... Date ..... / ..... / .....

**NHS Blood Donor registration:** I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years

Mr / Mrs / Miss / Ms (delete as appropriate)

Surname ..... First names .....

Signature confirming consent to inclusion on the NHS Blood Donor Register:.....

Preferred address for donation: (only if different from above, for example, your place of work)

.....Postcode .....

**For more information please visit: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) and [www.blood.co.uk](http://www.blood.co.uk)**

**Contract of Care**







# Patient Health Questionnaire

**Please complete the following:**

**If you know your height and weight:**

Weight:..... Kg / or St / Lbs Height:..... cm/m/feet/inches

**Smoking – please tick:**

Ex-Smoker  Date or year stopped..... Never Smoked



Smoker  Number of cigarettes a day 1-9  10-19  20 or more

We have a Smoking Cessation Service to help smokers quit. If you smoke would you consider help to stop smoking?


Yes, I am happy for you to contact me  I shall make an appointment  No, I don't want to stop at present

## Alcohol

**One standard drink is...**

	Half pint of regular beer or cider		1 small glass of wine		1 single measure of spirits		1 small glass of sherry		1 single measure of aperitifs
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**The following quantities of alcohol contain more than 1 standard drink**

<b>2</b>	<b>3</b>	<b>1.5</b>	<b>2</b>	<b>4</b>	<b>2</b>	<b>9</b>
						
Pint of Regular beer/lager/cider	Pint of Premium beer/lager/cider	Alcopop or can/bottle of Regular Lager	Can of premium Lager or Strong Beer	Can of Super Strength Lager	Glass of wine (175ml)	Bottle of wine

**Please tick your answers:**

1) How often do you have a drink containing alcohol?

NEVER	MONTHLY OR LESS	2-4 TIMES PER MONTH	2-3 TIMES PER WEEK	4+ TIMES PER WEEK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2) How many units of alcohol do you drink on a typical day when you are drinking (see diagram above)?

1-2	3-4	5-6	7-9	10+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3) How often have you had 6 or more units (females) or 8 or more units (males) on a single occasion in the last year?

NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST EVERY DAY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Allergies if known:** Reaction such as all over rash, (not just tummy upset or loose motions)

Penicillin..... Aspirin..... Other.....

## HAVE YOU HAD ANY OF THE CONDITIONS BELOW?

CONDITION	YES/NO	APPROX DATE	CURRENTLY ACTIVE/BEING TREATED?
ANXIETY / DEPRESSION			
ASTHMA			
ATRIAL FIBRILLATION			
CANCER, PLEASE SPECIFY			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)			
CONTRACEPTIVE IMPLANT			
CONTRACEPTIVE COIL			
CORONARY HEART DISEASE			
DIABETES			
EPILEPSY			
HIGH BLOOD PRESSURE (HYPERTENSION)			
INFECTION RISK, SUCH AS HEPATITIS B, HIV,			
OTHER PSYCHIATRIC CONDITION, PLEASE SPECIFY			
OVER ACTIVE THYROID			
PREVIOUS ATTEMPTED SUICIDE			
RHEUMATOID ARTHRITIS			
STROKE			
SUBSTANCE MISUSE			
UNDER ACTIVE THYROID			

**Significant family history:** Do you have a first degree relative (Brother, Sister, Mother or Father) who has suffered from the following? Include only men suffering first before age 55 and women who suffered first below 65.

FAMILY HISTORY IN A FIRST DEGREE RELATIVE AGED UNDER 60 OF:-	WHICH RELATIVE AND APPROX AGE AT START OF EVENT
ANGINA, HEART ATTACK, BY PASS SURGERY	
STROKE	
HIGH BLOOD PRESSURE	
TYPE 1 DIABETES	
TYPE 2 DIABETES	

### Children Under 16

Does the child live with someone other than a parent? Y  N

If Yes please give details of person/authority with parental responsibility including contact details.....

Relationship to child:

Is there is an allocated social worker Y  N

Please give details including contact number/email address:

Any other significant information we should be aware of

# Application for Online Access to Medical Records

Surname	Date of birth
First name	
Address	
Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

Booking appointments	
Requesting repeat prescriptions	

I wish to access my medical record online and understand and agree with each statement (tick)

I have read and understood the information leaflet provided by the practice	
I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	

Signature	Date
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**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE SURGERY WITH ONE  
PIECE OF PHOTGRAPHIC ID AND ONE PROOF OF ADDRESS FROM THE LIST ON PAGE 2  
PLEASE ALLOW UP TO 40 DAYS FOR PROCESSING**

**TO BE COMPLETED BY THE PRACTICE STAFF**

Patient NHS number		EMIS number	
Identity verified by (initials)	Date	Method (from approved list): Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/>	
Authorised by GP: Authorised by Manager: Signed:			Date
Date account created		Record coded: EMISNQON23 <input type="checkbox"/>	
Date passphrase sent		Major alert added <input type="checkbox"/>	
Level of record access enabled Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Detailed coded <input type="checkbox"/>		Notes / explanation	