**Access to SYSTM ONLINE**

**Patients can now access their Medical Information, Book and Cancel Appointments, and Order Medication via the internet using SYSTMONLINE.**

**Please see our website** [**WWW.WoodviewMedicalCentre.co.uk**](http://WWW.WoodviewMedicalCentre.co.uk) **for more information and a link to the site.**

**Please note this system does not work abroad. Prescription requests take 72 hours to process.**

|  |  |  |
| --- | --- | --- |
| **1.** | **I have read and understood the information leaflet provided by the practice** | **🞎** |
| **2.** | **I will be responsible for the security of the information that I see or download** | **🞎** |
| **3.** | **If I choose to share my information with anyone else, this is at my own risk** | **🞎** |
| **4.** | **If I suspect that my account has been accessed by someone without my agreement,I will contact the practice as soon as possible** | **🞎** |
| **5.** | **If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible** | **🞎** |
| **6.** | **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** | **🞎** |
| **7.** | **I would like to access my full clinical record from the date I am registered at the surgery** | **🞎** |

**NEW PATIENT CHECK LIST (For Admin Use)**

|  |
| --- |
| **RECEPTION IN PRACTICE AREA****All QUESTIONS COMPLETE****PROOF OF ID & ADDRESS****OVER 16YRS BP TAKEN****EVIDENCE OF CHILD IMMUNISATIONS****CHECKED BY****DATE** |
| **ADMIN PATIENT ACCEPTANCE LETTER SENT****PATIENT REG FOR SYSTMONLINE****REGISTERED BY****REG DATE** |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Valid Passport** | **Full Birth Certificate** | **Valid Photo Driving Licence** | **New born baby**  **(Red book)** |
| **Utility Bill** | **Bank Statement** | **Tenancy Agreement** | **Official Letter** |
| **Passport/Visa** | **Yes** | **No** |  |

**Please tick which documents you have provided as proof of ID and address (Must be dated within 3 months)** |

WOODVIEW MEDICAL CENTRE WELCOMES YOU



26 Holmecross Road

Thorplands

NN3 8AW

01604 670780

NEW PATIENT REGISTRATION FORMS

Once these forms are filled in and handed back, it will take 7-10 days to completely

register you. On completion, you will receive a confirmation letter via post.

Please confirm you are within our catchment area via our website [www.woodviewmedicalcentre.co.uk](http://www.woodviewmedicalcentre.co.uk), prior to completing this form.

We can only accept patients that are in this designated catchment area.

All patients must be present at time of registration.

Registration times are as follows:

Monday – Friday

12:45 – 13:45

OR

17:00 – 18:00

Every second Saturday of the month

09:00 – 11:00

New Patient Application Form

*(Please complete a separate form for each member of the family)*

|  |  |
| --- | --- |
| Title | Date of Birth |
| First Name | Surname (Family Name) |
| Occupation | Previous Surnames |
| Current Home Address | Home Telephone Number |
| Work Telephone Number |
| Mobile Telephone Number |
| Email address |
| Post Code | NHS Number if known |
| Preferred method of communication (please circle) SMS EMAIL LETTER |
| * Are you currently serving in the Armed forces as a Regular?
 | YES / NO |
| * Are you currently serving in the Armed forces as a Reserve?
 | YES / NO |
| * Are you an Armed forces Veteran?
 | YES / NO |
| How long do you intend to live at your new address? | Less than 6 months |  | More than 6 months |  |
| If you are new to the UK please give date of entry |  |
| Next of Kin Details |
| Name | Address |
| Relationship | Telephone Number |

NOMINATE YOUR PHARMACY NOW!

Please use our online system to order your prescriptions to be dispensed at a pharmacy of your choice.

PLEASE NOTE - If your medication is classed as a controlled drug, you will need to discuss your options with one of our prescription clerks.

Please nominate your chosen Pharmacy below

Repeat Medications:

Please allow 72 hours for prescriptions to be processed and make sure that medication is ordered before you run out of your medication. Requests can be made using one of the following options;

(1). POST – Woodview Medical Centre, 26 Holmecross Road, Northampton NN3 8AW

(2). SYSTMONLINE – Book your appointments and prescriptions on our website [www.woodviewmedicalcentre.co.uk](http://www.woodviewmedicalcentre.co.uk), or using your smart phone. (please ask at reception for more information).

 (3) IN SURGERY – Please post requests in the red box in the surgery.

HOME VISITS:

Home visits are for patients who are clinically unable and not those that are unwilling to come to surgery.
These would be reserved for physically housebound patients or end of life care. We do not visit children. Parents are expected to bring them into the surgery. Lack of transport, money and social reasons are not accepted. Please refer to our home visit policy on the website. A home visit request does not automatically guarantee a visit. The request will be triaged by the doctor who will decide if this is appropriate. All requests for visits must be in by 11:00 to be seen on the same day. It is unlikely a doctor would leave his/her surgery to attend a home visit, unless absolutely necessary.

CARE NAVIGATION:

Our reception staff are here to help you get the right service for your needs. When you call to make an appointment, don’t be offended if they ask you what the problem is and offer an alternative which may result in you getting seen quicker by a more appropriate service.

PATIENT DATA:

A copy of our privacy statement which details how we use your data and your rights can be found on the practice website www.woodviewmedicalcentre.co.uk.

**ID IS REQUIRED TO COLLECT ALL PRESCRIPTIONS**

**WE DO NOT ACCEPT PRESCIPTION REQUESTS OVER THE PHONE.**

Thank you for helping us to help you!

You will also be required to provide 2 forms of identification (originals) (1 being proof of yourself and the other proof of your address).

I confirm that i have read and understood the Patient Information Leaflet in regards to booking appointments, home visits, ordering your prescriptions and fit/sick certificates and I agree to abide by them.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent /Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if applicable)**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any serious illness, operations or disabilities YOU have**

|  |  |
| --- | --- |
| **Details** | **Year** |

**Allergies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have any allergies?**  | **Yes** | **No** | **Please give details:** |
| **Are you allergic to any medicines** | **Yes** | **No** |  |

**Summary Care Record**

**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. The information will be taken from your GP record.**

**As a patient you have a choice - please indicate below**

|  |  |
| --- | --- |
| **Yes I would like a summary care record** |  |
| **No I do not want a summary care record** |  |

**If you require further information about making your choice please ask at reception.**

PATIENT AND PRACTICE AGREEMENT

Consultations are strictly by appointment only and are issued at the next available time.

Please be punctual for your appointment – There is no guarantee that you will be seen if you are more than 10 minutes late.

We aim to provide you with the best possible service. In return, a polite manner when dealing with staff would be appreciated.

Please note – New patients are required to book an appointment with the doctor if you are taking repeat medications.

If you are planning to leave the UK for more than 3 months you need to notify the surgery.

APPOINTMENTS:

Appointments are bookable either by contacting the surgery via telephone or by use of our systmonline or automated telephone system. To book online, please ask at reception for details.

Please assist staff by letting them know the problem briefly. Just 1-2 words will do without any details so they can direct you to the most appropriate service (e.g. chest infection, asthma, epilepsy review or needing sutures removed, sore throat, sprain etc.)

Certain illnesses can be treated by our experienced minor illness nursing team. If necessary, the doctor will review afterwards on the same day.

Please do not abuse the urgent appointments available for such problems as corns, warts, fungal nail infections, acne, cholesterol tests, routine referrals, sick notes etc.
Persistent offenders will be removed from the list

**Ethnic Origin – Please tick appropriate box**

***This information will help to plan services to meet the needs of all patients***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White** | British |  | Irish |  | Other |  | Other white background |  |
| **Black** | Caribbean |  | African |  | Other |  | Other Black background |  |
| **Asian** | Indian |  | Pakistani |  | Bangladeshi |  | Other Asian background |  |
| **Mixed** | White and black Caribbean |  | White and black African |  | White and Asian |  | Other Mixed Background |  |
| **Other Ethnicity** | Chinese |  | OtherPlease state | **Religion**  |
| **What is your first language** |  | **Do you require an Interpreter ?**  |  |

**Do you support someone who is disabled, elderly or with an addiction?**

|  |  |  |
| --- | --- | --- |
| **Do you support someone with their daily activities/ Does somebody support you?** | **Yes someone** **supports me** | **Yes I support** **someone else** |
| **Please give details****Name:** | **Registered at Woodview?****YES NO** | **Relationship:** |

**Family History**

**Please tick if anyone in your close family (i.e. parents, bother and sisters) have suffered from any of the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Relative** | **Age at onset** |  | **Relative** | **Age at onset** |
| **Angina** |  |  | **Eczema** |  |  |
| **Asthma** |  |  | **Epilepsy** |  |  |
| **Blindness/****Glaucoma** |  |  | **Heart Attack** |  |  |
| **Breast Cancer** |  |  | **High Blood Pressure** |  |  |
| **Other Cancer** |  |  | **Sickle Cell** |  |  |
| **Depression** |  |  | **Stroke** |  |  |
| **Diabetes** |  |  | **Thalassaemia** |  |  |

**Other Information**

|  |  |  |
| --- | --- | --- |
| **Are you registered disabled?** | **Yes** | **No** |

**Mobility**

|  |  |  |
| --- | --- | --- |
| **Are you housebound?** | **Yes** | **No** |

**For patients under 18 only**

|  |  |
| --- | --- |
| **Please provide the name of the school/nursery attended** |  |
| **Please mark which Immunisations have been received. Also provide evidence of these vaccinations.**  |
|

|  |  |
| --- | --- |
| **AGE** | **Immunisation (Vaccine Given)** |
| **2 months** | * [**DTaP/IPV(polio)/Hib/HepB**](https://patient.info/health/immunisation/dtap-polio-and-hib-immunisation) (diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b and hepatitis B)
* [**PCV**](https://patient.info/health/immunisation/pneumococcal-immunisation) (pneumococcal conjugate vaccine)
* [**Rotavirus**](https://patient.info/health/acute-diarrhoea-in-children/rotavirus) - oral route (drops).
* [**Meningitis B**](https://patient.info/health/meningitis-leaflet/meningococcal-meningitis-vaccine)
 |
| **3 months** | * **DTaP/IPV(polio)/Hib/HepB** 2nd dose
* **Rotavirus** - oral route (drops).
 |
| **4 months** | * **DTaP/IPV(polio)/Hib/HepB** 3rd dose
* **PCV** 2nd dose
* **Meningitis B** 2nd dose
 |
| **Between 12 and 13 months** | * **Hib/MenC** - 4th dose of Hib and 1st dose of MenC plus:
* [**MMR**](https://patient.info/health/immunisation/mmr-immunisation) (measles, mumps and rubella)
* **PCV** 3rd dose
* **Meningitis B** 3rd dose
 |
| **3 years and four months**  | * **Preschool booster of DTaP/IPV(polio)**. (diphtheria, tetanus, pertussis (whooping cough), polio)
* **MMR** 2nd dose
 |
| **12-13 years (girls)** | * [**HPV**](https://patient.info/health/immunisation/human-papillomavirus-immunisation-hpv) (human papillomavirus types 16 and 18) - **two** injections (Gardasil®). The second injection is given 6-12 months after the first one.
 |
| **14 years** | * **Td/IPV(polio) booster**. (diphtheria, tetanus, polio, )
* **Men ACWY**: combined protection against meningitis A, C, W and Y
 |

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|  |
| --- |
| **Please give details of anyone who may access information about your child** (ie father/mother with names & contact details) |

|  |
| --- |
| **Do you have, or have you ever had a Social Worker involved in your family? YES / NO**If so please give details.  |

**For patients over 14 only**

**ALCOHOL SCREENING**

**Fast Alcohol Screening test (FAST)**

|  |  |
| --- | --- |
| **FAST ALCOHOL SCREENING TEST****Only answer questions 2, 3 and 4 if your answer to question 1 is monthly or less**

|  |
| --- |
| **1) How often do you have 8 (men) / 6 □ N/A □ Never(0) □ Less than monthly (1) □ Monthly (2)** **(women) or more drinks on one occasion? □ Weekly (3) □ Daily or almost daily (4)** **………………………………………………………………………………………………………………...** **2) How often in the last year have you not □ N/A □ Never(0) □ Less than monthly (1) □ Monthly (2)** **been able to remember what happened □ Weekly (3) □ Daily or almost daily (4)** **when drinking the night before?** **………………………………………………………………………………………………………………...** **3) How often in the last year have you □ N/A □ Never(0) □ Less than monthly (1) □ Monthly (2)** **failed to do what was expected of you □ Weekly (3) □ Daily or almost daily (4)** **because of your drinking?** **……………………………………………………………………………………………………………………………...** **4) Has a relative/friend/doctor/health □ N/A □ No (0) □Yes, but not in the last year (2)** **worker been concerned about your □ Yes, during the last year (4)** **drinking or advised you to cut down?** **…………………………………………………………………………………………………………………………......** **Alcohol screen – fast alcohol screening** **test completed** |

 |

**Medical Information**

**Smoking**

|  |  |
| --- | --- |
| **Smoker – How many cigarettes smoked a day?** | **Number:** |
| **Past Smoker – When did you give up?** | **Date:** |
| **Never Smoked** | **Please tick:** |

Please use patient blood pressure machine to take your blood pressure and record the results here.

|  |  |  |
| --- | --- | --- |
| **Reading 1** **…………………/……………. Pulse ………..** | **Reading 2****…………………/……………. Pulse ………..** | **Reading 3** **…………………/……………. Pulse ………..** |