**Welcome to the Belmont Health Centre – ADULT FORM**

Thank you for completing this questionnaire. All information you give is confidential and will be held on your medical records. Please can you: Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Date of birth |  |
| Email address  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do NOT wish to be contacted by email or SMS. ☐ |
| **Who should we contact in an emergency?** |
| Name  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship |  |
| Telephone number |  |

**Ethnicity**

What is your country of birth? What is your first language?

Do you require an interpreter?

☐ White British

☐Other White ethnic group

☐ Black British

☐ Black Caribbean

☐ Black African

☐ Black other

☐ Other Black ethnic group

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Vietnamese

☐ Other Asian ethnic group

☐ I do not wish to state my ethnic group

☐ Other ethnic group (please state):

**Religion**

☐No religion

☐Christian

☐Buddhist

☐Hindu

☐Jewish

☐Muslim

☐Sikh

☐Any other religion (please state

**Measurements**

**Height:** Feet/inches: Metres:

**Weight:** Stones: Kg:

**Waist:** Inches: Centimetres:

**Exercise:** Do you take exercise that lasts for at least 20 minutes per session? ☐ Yes ☐No

If yes, how many times a week? ☐ 1 ☐ 2 ☐ 3+

**Do you work?**

☐Employed ☐Self-employed ☐Unemployed ☐Homemaker ☐Student ☐Retired

What is your current occupation?

**Carer/Housebound Information**

Do you have a Carer? ☐ Name and contact no. of Carer:

Are you a Carer? ☐ Name of person you care for:

Are you housebound? ☐

**Family History**

|  |  |  |
| --- | --- | --- |
|  |  | Details, for example Father, Mother, Sister |
| ☐ | Raised Cholesterol |  |
| ☐ | Stroke |  |
| ☐ | Heart Disease before the age of 60 |  |
| ☐ | Heart Disease after the age of 60 |  |
| ☐ | Asthma |  |
| ☐ | Cancer |  |
| ☐ | Diabetes |  |

Have any of your close family (parents/brother/sister) had any of these illnesses or conditions?

**Past Medical history:** Please list with dates and **significant** current or past illnesses, operations or allergies

|  |  |
| --- | --- |
| **Illness, Operation Or Allergy** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**Women Only**

Are you pregnant? ☐Yes ☐No If yes, when is your baby due?

When was your last cervical smear examination? Result:

When was your last Breast screening X-ray (mammogram)? Result:

What type of contraception do you use, if any?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ | Oral contraception (the Pill) | ☐ | Diaphragm | ☐ | Contraception not needed |
| ☐ | Condom (sheath) | ☐ | Patch (transdermal) | ☐ | No current contraception |
| ☐ | Depot Injection | ☐ | Ring (Nuvaring) | ☐ | Other (please state) |
| ☐ | Coil (IUD-Intrauterine) | ☐ | Implant (Implanon/Nexplanon) |

**Drugs and Medications:** If you require any medication, you must make an appointment with a Doctor for this to be issued. Please bring your repeat medication slip or attach your last prescription.

**Thank you for your time and help in completing this questionnaire**

*Issuing of the registration documents does not guarantee registration with this Practice*

**For office use only**

**Proof of ID seen:** ☐ Yes ☐ No

Document Initials/Date

**Proof of address seen (e.g. Utility bill):** ☐ Yes ☐ No

(NPM)

Appointment Booked Date

**Consent Form**

**DR J J WIJERATNE & PARTNERS**

**BELMONT HEALTH CENTRE**

**516 KENTON LANE, HARROW, MIDDLESEX HA3 7LT**

|  |  |
| --- | --- |
|  Dr Wijith Wijeratne, BM, MRCP(UK) |  Dr I Ekneligoda MD, MD(Paed), MRCPCH, DFFP |
|  Dr S Wijendra, MB, BS, LRCP, FRCS, FRCS(Edin) |  Dr J Tanna, MBBS, BSc, MRCGP, DRCOG |
|   |  Dr M Munasinghe, BSc, MBChB, MRCP, MRCGP, DRCOG  |
|  **Tel: 020 8863 6863** | **Appointments Tel: 020 8861 5663** |  **Fax: 020 8424 0542** |
|  | **(www.belmonthealthcentre.co.uk)** |  |

Name: …………………………………………………………………………………………………

Date of Birth:……………………………………………………………………………………….

Address: ……………………………………………………………………………………………

……………………………………………………………………………………………………….

I give permission for the following person/s:

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify)…………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify)…………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify) …………………………………………………………………….

To be able to do the following on my behalf at Belmont Health Centre (Dr J J Wijeratne & Partners)

☐ Book appointments ☐ Cancel appointments

☐ Request prescriptions ☐ Collect prescriptions

☐ Surgery to leave messages with this person relating to myself ☐ Check test results

☐ I understand that it is my responsibility to inform the surgery if the above information changes in the future.

Signature: ……………………………………………………………………………………

Date: …………………………………………………………………………………………

EPS-NOM-001

 DR J WIJERATNE & PARTNERS

**Patient Online Registration Form**

**Access to GP online services**

****

Surname

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | I wish to |
| First name |  |  |  |  |
|  |  |  |  | have |
|  |  |  |  |  |  |
|  |  |  |  |  |  | access to |
| Date of birth |  |  |  |  |
|  |  |  |  | the |
|  |  |  |  |  |  |
|  |  |  |  |  | following |
| Address |  |  |  |  |
|  |  |  |  |  |  | online |
|  |  |  |  |  |  | services |
| Postcode |  |  |  |  | (tick all |
|  |  |  |  |  |  | that |
| Email address |  |  |  |  | apply): |
|  |  |  |  |  |  |
| Telephone number | Mobile number |  |  |  |  |
|  |  |  |  |  |  |  |
| 1. | Booking appointments |  |  |  |  |  |
|  |  |  |  |  |
| 2. | Requesting repeat prescriptions |  |  |  |  |  |
|  |  |  |  |  |
| 3. Accessing my detailed coded medical record |  |  |  |
|  |  |  |

**Application for online access to my medical record**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1. | I have read and understood the information on the reverse of this form |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | 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. | I will contact the practice as soon as possible if I suspect that my account |  |  |  |
|  |  | has been accessed by someone without my agreement |  |  |  |
|  | 5. | If I see information in my record that it not about me, or is inaccurate I will |  |  |  |
|  |  | log out immediately and contact the practice as soon as possible |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Patient |  |  |  | Date |  |  |  |
|  | Signature |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | **For practice use only** |  |  |  |  |  |  |
|  |  |  |  |  |
|  | **Photo ID** (Please tick) | **Address ID (last 3 months)** (Please tick) |  |  |
|  |  |  |  |  |
|  | Passport | Utility Bill |  |  |
|  | Driving Licence | Bank or credit card statement |  |  |
|  | Bus Pass | Benefit statement |  |  |
|  | Firearms Licence | *(NOT mobile phone bill please)* |  |  |
|  | Other |  |  | *Other* |  |  |
|  | **Receptionist Initials** |  |  |  |  |  |  |

**Important Information – Please read before returning this form**

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.

**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.**

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.

**Forgotten history** There may be something you have forgotten about in your record that you might findupsetting.

**Abnormal results or bad news** If your GP has given you access to test results or letters, you may seesomething 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’sup to you whether or not you share yourinformation 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 elseagainst 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 ensurethat 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 anyother errors, please log out of the system immediately and contact the practice as soon as possible.

**Proxy Access:** Parents may request a proxy access to theirchildren’srecords; this will cease automaticallywhen the child reaches the age of 13. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

|  |
| --- |
| **Electronic Prescription Service****Patient Nomination Request** |
| **Patient name** ………………………………………………………………………………………………**Address** …………………………………………………………………………………………………………………………………………………………………………………………………………………………… Telephone Number…….………………………………………………………………………………… DOB………………….………………………………………………………………………………………. NHS Number ……………………………………………………………………………………………… |
| **I am the patient named above. Nomination has been explained to me by staff at my GP practice/community pharmacy/appliance contractor. I have also been given a leaflet about this. I have read the Nomination Leaflet and understand what I have to do. I will inform the pharmacy that I have nominated them.****I am the patient’s parent, guardian, carer, patient advocate (delete as appropriate) and nominating on behalf of the above named patient****NAME: ADDRESS:** |
| Name and address of nominated dispenser: |
| **Patient/Patient Representative Signature:** …………………………………………………………………………**Patient/Patient Representative Phone Number:** …………………….…………………………………………**Patient Telephone Numbers: Home:****Mobile:****Work:****Patient email address:** ………………………………………………………………….…………………………….**Staff Signature:** ………………………………………………………………….…………………………….**Date**………………………………………………………………….……………………………. |