WESTWAY Medical Centre

Caring for the whole family

Westway, Maghull, L31 0DJ

Tel: 0151-526 1121
Fax: 0151-295 8552

SSCCG.N84025@nhs.net
westwaymcmaghull.nhs.uk

REF: New Patient Registration **DATE: ……**

Dear New Patient

We are pleased that you wish to join this practice. Would you kindly complete the attached New Patient Questionnaire and Registration Form and hand it in to Reception together with photo ID, along with one document from the following list containing your address for the Receptionist to verify.

Documents to be verified by Admin – please tick below the documents verified
Purple form checked (all details) –
Questionnaire completed -
ID verified (2)-

- Birth certificate
- Marriage certificate
- Paid utility bills
- Bank/building society cards/statements/passport

If you live outside the home visit boundary you may register as an out-of-area patient but need to also fill in the out of area patient registration form.

You will not be registered with this practice until all these forms are completed, signed and returned to the receptionist. We will then offer you a health examination with our Practice Nurse which will give you the opportunity to discuss any particular problems or concerns you may have about your health and lifestyle.

Yours sincerely

Westway Medical Centre

OUT OF AREA PATIENT REGISTRATION ONLY COMPLETE BELOW

CRITERIA FOR PATIENTS NOT SUITABLE FOR OUT OF AREA REGISTRATION DUE TO CLINICAL NEEDS:-

1). Age 75 and over
2). Significant mobility issues, must be able to ride in a car
3). Requiring community services input ie: District Nurses/Palliative care
4). Prescribed 10 or more medications
5). Treated for chronic breathlessness

- **I am hereby registering as an out-of-area patient at Westway Medical Centre**
- **I understand that this excludes me from home visits**
- **I understand that if my clinical situation changes in that I may require home visits it is within the right of Westway Medical Centre to request that I register with a local GP practice.**

Name:……

Signed: ……

Date: ……

Thank you for completing this questionnaire, welcome to Westway Medical Centre

NEW PATIENT REGISTRATION/ HEALTH QUESTIONNAIRE

To the Patient:

To register with the practice, please complete this questionnaire as fully as possible. The information will help the Practice Nurse make an initial assessment of your health which will help in your future treatment.

Surname: ……Forename(s): ……..……

Date of Birth: ……..

Marital status: …..…….. Previous Surname: ……

Address:
……..……

……

……..……..……

Postcode: ...……..…….

Home tel: ……..……..……..……

Mobile: ……

Email address:
……

Occupation:
……

Weight (approx): ……..……..…….. Height: ……

Westway Medical Centre uses text messages to communicate and send patient key information

I consent to being contacted by the practice text message or email via email regarding my health and appointment reminders ☐

I consent to being contacted by the practice text message or email via email regarding practice news ☐

Date of completion of this form: …….

Ethnic Origin

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

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

First language

APPOINTMENTS

We will try our best to accommodate your request this will include sign posting you to other appropriate services. Routine appointments can be booked on line or by contacting the surgery. When you telephone for an urgent on the day appointment we would be grateful if you could provide the receptionist with brief details of your problem so that you can be offered an appointment with the most appropriate member of the team, this maybe with the Nurse Practitioner, Practice Nurse or Pharmacist.

Please note a standard GP appointment is 10 minutes, if you are seeking to address multiple problems please consider requesting a double appointment.

LIFESTYLE

Height …… Weight ……..

Do you smoke YES / NO (please circle) if YES, how many ……../per day
if ex-smoker, when did you quit ……

How much alcohol do you drink a week …… units / per week
(1 spirit = 1 glass of wine = ½ pint = 1 unit)

Do you take regular exercise - YES / NO (please circle) if YES, …… times per week

Do you drive - YES / NO (please circle)

Do you have any mobility problems/special needs - YES / NO (please circle)

please specify …….

Diet

Do you have a varied diet including milk, meat, vegetables and fruit? *Yes* / *No*

Has your cholesterol been checked in the last two years? *Yes* / *No*

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease (e.g. heart attacks, angina) *Yes* / *No* which family member? …….

Stroke *Yes* / *No* which family member?
……

Cancer *Yes* / *No* which family member?
……

Site of cancer?
……

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……
Dosage: ……

Name of drug: ……
Dosage: ……

Name of drug: ……
Dosage: ……

Name of drug: ……
Dosage: ……

Nominated Chemist of your choice…….

Allergies

Are you allergic to any substances, including medication or foods? *Yes* / *No*

If *Yes*, please give details:

……
……
……
……

Past Medical History

Please include any details any diagnoses and any hospital treatment as an in-patient:

……
……

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……
……
……
……
……

Please give details of any treatment for any chronic medical conditions:

……
……
……
……

Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound:

……
……
……
……

Immunisations

List all in the last

5years……

……..……

……

Female Patients

Date of most recent cervical smear: ……..

Result of most recent smear: ……..

Please give details of any complications in pregnancy:

……

……

Carers

Does someone look after you? Or do you need / have anyone who looks after you or your daily needs as a Carer? *Yes* / *No*

If *yes*, would you like them to deal with your health affairs here?
Yes / *No*

The receptionist can help with these arrangements

Do you care for someone else? (excluding children 0-18years)

Yes / *No*

If *yes*, please ask the receptionist about Carers support

NHS SUMMARY CARE RECORD

You do not need to do anything this will happen automatically. Healthcare staff will ask your permission every time they look at your summary care record.

If you don't want a summary care record please ask for an opt out form at reception.

E-CONSULT - HOW IT WORKS

1) Visit out practice website - www.westwaymcmaghull.nhs.uk
2) Click on E-consult banner
3) Select self-help or consultation options

NHS APP

Down load the NHS app onto your phone for on line services, for more information log onto
https://www.nhs.uk/

BOOKING YOUR APPOINTMENTS ON LINE

If you are interested in booking your appointments on line, please register for online services by providing your email address:

……

General

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

……

……

ARE YOU A WAR VETERAN -

Yes ☐ No ☐ (Please tick as required)

PATIENT PARTICIPATION GROUP

As a new patient you qualify to join our patient group. Would you like to join?

Yes ☐ No ☐ (Please tick as required)

DISABILITY

Please advise us if you have any specific information or communication needs-

……

……