DR KILLY & PARTNERS

TELEPHONE - 01376 337272

PLEASE READ CAREFULLY BEFORE FILLING IN THE FORMS

Registration forms must be completed in **FULL**

Please bring in **one** form of ID this can be a utility bill or photo id (passport, driving Licence) & your NHS number (if known, as this will help speed up locating your records and avoid delay)
This can be found on NHS letters, Via contacting your previous surgery and/or by searching online.

PLEASE NOTE – WE ONLY ACCEPT NEW PATIENTS THAT LIVE WITHIN THE **CM8** POSTCODE

OPENING HOURS

MON – FRI 08:30 – 18:00

Telephone lines are open until 08:00-18:30

WE SUPPORT THE NHS ZERO TOLERANCE CAMPAIGN

PLEASE MAKE SURE YOU FILL IN ALL REQUESTED INFORMATION AND SIGN ALL FORMS. WITHOUT THIS IT MAY DELAY IN REGISTERING YOU. ANY QUERIES PRIOR TO REGISTERING, PLEASE SPEAK TO RECEPTION.

NEW PATIENT QUESTIONNAIRE

When you have completed this form please hand in to reception with required documents. The information will be held in your personal records which like all NHS records, remain confidential.

PERSONAL DETAILS (PLEASE USE CAPITALS)

Mobile___________________________________ Home___________________________________

Preferred Contact __________________________________ Other contact _______________________

Consent to SMS YES NO

Email address ____

Occupation ____

Please specify your first language ____

If English is not your first language, do you speak English? Yes No

Ethnicity ____

Do you care for someone who is frail ill disabled or mentally ill? Yes No

Are you looked after or supported because you are frail, disabled or mentally ill? Yes No

Do you have communication difficulties? Yes No

Please give your approximate weight_____________________height_______________________

SMOKING

Smoker_____________ Never Smoked _____________ Non-Smoker (Approx Date Quit)____________

If smoker, how many on average per day___________ How long have you smoked for_______________

Do you wish to stop smoking? If so we can refer you, by selecting YES you agree to be referred to Essex Wellbeing Service: Yes No

CURRENT MEDICATION

Please attach a copy of your current medication from your previous GP and ensure you have enough to

last you at least 4 weeks as it can take time for your notes to come across and for the surgery to set up your repeat prescription.

Please confirm which pharmacy you would like your prescriptions to go to if you do not do this we will nominate one on your behalf as all prescription are now ETP (Prescribed Electronically)_____________________

ALLERGIES

Please list any allergies you may have such as medication, animals, pollen, nuts, hayfever etc

Have you ever had an adverse reaction Yes No

NEXT OF KIN

Next of Kin ___________________________________ Relationship to you ________________________

Contact Number_____________________

PLEASE NOTE, NEXT OF KIN **DOES NOT** GIVE THEM PERMISSION TO ACCESS / DISCUSS YOUR MEDICAL RECORDS OR RESULTS ETC – IF YOU WOULD LIKE THIS FACILITY, PLEASE REQUEST A CONSENT FORM AT RECEPTION

Please sign if you agree to share your record with relevant third parties (this includes hospital, walk in centre, AED and other surgeries if seen there)

I agree to share information with third parties if needed

All information listed on this registration (Inc your Next of Kin) will be recorded within your medical records

Signature:

NEW PATIENTS OVER 40: WE WOULD LIKE YOU TO OFFER YOU A NEW PATIENT HEALTH CHECK WHICH INCLUDES A FASTING BLOOD TEST. YOU CAN CALL AND BOOK THIS APPROX 1 WEEK AFTER REGISTERING. WE LOOK FORWARD TO SEEING YOU.

systmonline™

BOOK REQUEST REGISTER

PLEASE NOTE – Due to increasing changes within the NHS, we request that all new patients complete this form; you will be able to book appointments, request repeat prescriptions and access your medical records online.

Please tick one of the following whether you would like us to:

Print out your log in details for you to collect from reception ☐

Send your log in details by SMS message ☐

Send your log in details by email ☐

Signature: ________________________________ Date:

For Practice Use Only

Identity verified through: Vouching ☐ Date Verified:__________________

Vouching with information in record ☐

Photo ID ☐

Proof of residence ☐

Name of person who authorised (if applicable) __________________________

Date account created and log in details sent:

Dr Killy & Partners

PATIENT'S AGREEMENT

On joining Dr Killy & Partners at the Witham Health Centre I have read and agree to the following:-

- I understand that by not turning up for appointments, I am denying patients who are unwell and need to be seen the opportunity of being offered an appointment. I will therefore inform the surgery if I am unable to attend an appointment.

- I must be prepared to see a nurse instead of a doctor for minor illness, or when advised that this is appropriate. (Please note our nurses are skilled and an essential part of our patient care team, helping free up the doctors' time for patients with more complex problems).

- I accept and understand that the length of a routine appointment with the Doctor is 10 minutes. We try to keep to appointments times, but sometimes one patient may need more time and you may have to wait a little longer. It maybe you who needs some extra time so please bear with us. If you inform reception when booking the appointment, it ensures that we as a practice can allocate accordingly to your needs.

- I accept and understand that I will not be abusive towards the reception/administration staff. **We do NOT tolerate targeted abuse against members of staff and any social media posts against staff personally may result in a removal from the practice list.** It is with regret that we now ask ALL patients to agree not to be abusive to any of our staff. We find this kind of behaviour is increasing. The surgery has a policy of **ZERO TOLERANCE** and therefore will **REMOVE** any such patient from our practice list should they breach our policy.

I understand and agree to the above policy:-

PRINT NAME ……………………………………………………………………………………

SIGNATURE ……………………………………………………………………………………

DATE ……………………………………………………………………………………………..

If you have any concerns regarding the above please ask to speak to the Practice Manager.

Thank you.

ARE YOU A CARER

If you are looking after a relative or friend who is elderly or has an illness, including mental health problems, or a disability, you are a carer.
Or
If you are looking after a child who has an illness or learning difficulties, you are a carer.

This surgery values carers and is working with Action for Family Carers across Essex to support you in your caring role. If you are a carer, please fill in your details below and hand the form into reception.

Carer

Name:
Address:
Telephone No:
E-mail address:

Details of Person cared for

Name:
Address:
Telephone No: (if different from above)
Relationship to Carer:

Consent of Carer

I consent to the above details regarding my Carer status being recorded in my medical records. Signature: Date:

Consent of Person Cared For

I consent to the disclosure by The Witham Health Centre of such clinical information as may be considered necessary by the doctor to the carer named above. Signature: Date:

Name of GP:

……………………………………………………………………………….

Surgery use only

	Initials	*Date*
Entered into Carer's notes - Ub1ju		
Entered onto notes of person Cared for - .918F		
Consent entered in both patients' notes if relevant		

Action for Family Carers supporting Carers across Essex are a Carers Trust Network Partner and Centre of Excellence, they hold a PQASSO level 3, NCVO's highest quality mark for charity management and governance and they provide support and advice to carers.

A Carer which contacts Action for Family Carers supporting Carers across Essex can:

- Receive information on their rights
- Information on financial and legal matters
- Explaining power of attorney
- Support to access grant funding
- Helping you plan for an emergency
- Respite day care across the county
- Offer free, confidential counselling service
- Telephone befriending

Please tick the appropriate box if you would like:

- The surgery to pass your details on to the Action for Family Carers ☐
- A support worker from Action for Family Carers to telephone you ☐