

REDGATE MEDICAL CENTRE
www.redgatemedicalcentre.nhs.uk



Westonzoyland Road
Bridgwater
Somerset
TA6 5BF
Tel: 01278 454560
Fax: 01278 446816

Dear Patient

Welcome and thank you for choosing to register with Redgate Medical Centre.

Here at Redgate we have a team of highly skilled doctors, advanced nurse practitioners and practice nurses working to provide patients with the best care possible. We work closely with our district nurses, health visitors, and midwives. To support all these services we have a hard working team of health care assistants, administrative and reception staff.

Appointments can be booked by telephone during our opening times or online - you will need to register for online services.

Pre-bookable (routine) appointments are available to book up to 6 weeks in advance. We also provide a Same Day Access service for urgent problems requiring treatment on the day.

Once registered you will be allocated and notified of your registered GP but you are most welcome to book an appointment with the doctor of your choice.

Kind Regards

Partners at Redgate Medical Centre

Dr D M Hynes MB BCH MSc FRCP(UK) DGM * Dr S J Akhter FRC
Also
Somerset Bridge Medical Centre Taunton Road, Bridgwater, Somerset TA6 6LD



**REDGATE MEDICAL CENTRE &
SOMERSET BRIDGE MEDICAL CENTRE**

Signing Up For Our Patient Participation Group

We are keen to involve patients in the development of our services and also to receive some feedback on how we are doing. If you are interested in getting involved please leave us your contact details below.

Your Name:

Postcode:

Please tick as applicable

I would be interested in attending regular Patient Participation Group Meetings

I would like to receive regular updates and take part in surveys via email

Telephone Contact No:

Email Address: (if applicable)

We are keen to know what sort of information patients would be interested to receive from the practice via email. From the list below, please tick those that you feel would be most useful to you.

- | | |
|---|--|
| <input type="checkbox"/> Patient Group Newsletters | <input type="checkbox"/> Agendas/Minutes of Patient Group Meetings |
| <input type="checkbox"/> Information about new clinics/services | <input type="checkbox"/> Other |
| <input type="checkbox"/> Carers Information | |
| <input type="checkbox"/> Patient Surveys | |

The information below will help to make sure that we receive feedback from a representative sample of the patients registered at this practice.

Your Gender: Male Female

Your Age: Under 16 17 – 24 25 – 34 35 – 44 45 – 54
55 – 64 65 – 74 75 – 84 Over 84

The ethnic background with which you most closely identify is:

White British Group Irish White Other

Mixed White & Black Caribbean White & Black African White & Asian

Asian or Asian British Indian Pakistani Bangladeshi

Black or Black British Caribbean African

Chinese or Other Chinese Any Other

How would you describe how often you come to the practice?

Regularly Occasionally Very rarely

Thank you for your support. Please note that we will not respond to any medical information or questions received through surveys

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ONLINE NEW REGISTRATION QUESTIONNAIRE

Welcome to Redgate Medical Centre:

To register with the practice, please complete this questionnaire as fully as possible to help your new GP get to know you and your medical history. It may take some time for your previous medical records to reach us so the information you give will help us to provide you with good medical care. The following table is for information only. **Please complete all fields from PERSONAL INFORMATION onwards.**

QUESTIONNAIRES and INFORMATION	INFORMATION	FOR OFFICE USE ONLY
New Patient Health Questionnaire	All newly registered patients must complete a general health questionnaire form	
Smoking Advice	All patients are offered information on quitting smoking if required	
Carers Form	If you are a carer or have a carer, please fill out the relevant form. This can be obtained from the receptionist at registration	
Repeat Medication Form	Please complete the attached form only if you are currently on any repeat medication	
Summary Care Record	Your Summary Care Record will be securely uploaded to the National Spine on signing this registration form so that wherever in the country you need care, healthcare professionals can have access to the most up-to-date information. PLEASE COMPLETE AND SIGN THE ATTACHED SUMMARY CARE RECORD FORM	
On-line Patient Access	This enables you 'the patient' to view your medication, any allergies or adverse reactions and immunisations. It also enables you to book appointments on-line and order repeat prescriptions	
Alcohol Questionnaire and information leaflet	All newly registered patients are asked to complete the attached form	
Proof of ID	All newly registered patients are requested to provide proof of ID (photo) and proof of current address	
Named GP	ONLINE APPLICATION – Please notify patient of named GP once registered	
Date Completed and Signature		

PERSONAL INFORMATION - PLEASE COMPLETE ALL THE FOLLOWING FIELDS

PERSONAL INFORMATION		
Title		Male/Female
Surname		Previous Surname
Forename(s)		
Date of Birth		Place of Birth
Occupation		
Home Telephone		
Mobile		Other

CURRENT Address		Postcode
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OTHER RELEVANT QUESTIONS

PREVIOUS Address		Postcode:
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Have you previously been registered with the surgery? YES NO

If YES, please provide us with your address details at that time

If you are from abroad	Date of when you first came into the country
Are you a military veteran:	If yes, Force served (Army, Royal Navy, RAF)

ETHNIC GROUP (Please TICK)					
White:	British <input type="checkbox"/>	Irish <input type="checkbox"/>	Polish <input type="checkbox"/>	Other <input type="checkbox"/>	
Black:	Black British <input type="checkbox"/>	African <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Other Black <input type="checkbox"/>	
Asian:	Asian British <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Indian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other Asian <input type="checkbox"/>
Mixed:	Asian & White <input type="checkbox"/>	Asian & Black <input type="checkbox"/>	Asian & Caribbean <input type="checkbox"/>	White African <input type="checkbox"/>	White Caribbean <input type="checkbox"/>
Other:	Chinese <input type="checkbox"/>	Japanese <input type="checkbox"/>	Middle Eastern <input type="checkbox"/>	Turkish <input type="checkbox"/>	
Any Other:					

What is your First Language:	What is your second Language:
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PATIENT CARE

Next of Kin (Name, Relationship & Contact Details)	
Do you have a carer?	Yes/No IF 'YES' PLEASE COMPLETE A CARERS IDENTIFICATION AND REFERRAL FORM
Are you a carer?	Yes/No IF 'YES' PLEASE COMPLETE A CARERS IDENTIFICATION AND REFERRAL FORM

PREFERRED PHARMACY – you can collect prescriptions from a Pharmacy of your choice

Where would you like your scripts to go? Please TICK:	North Petherton <input type="checkbox"/>	Victoria Park <input type="checkbox"/>
Superdrug <input type="checkbox"/>	Sainsbury's <input type="checkbox"/>	Somerset Bridge <input type="checkbox"/>
Rowlands <input type="checkbox"/>	Stockmoor <input type="checkbox"/>	LLOYDS: Redgate <input type="checkbox"/>
	Cranleigh Gardens <input type="checkbox"/>	Taunton Road <input type="checkbox"/>
	Boots <input type="checkbox"/>	Asda <input type="checkbox"/>

YOUR MEDICAL HISTORY (If you have any one of the diagnosis listed below, you will receive an annual review with a practice nurse during your Birthday Month)

CONDITION	DATE / YEAR OF DIAGNOSIS (If known)
Asthma	
Cancer	

COPD	
Diabetes	
Hypertension	
Epilepsy	
Heart attack/disease	
Osteoporosis	
Stroke	
Mental health problems	
Learning Disability/Difficulty	
Other serious illnesses	
Family History	Please state any serious illness, in particular heart disease, strokes, high blood pressure diabetes or any inherited disease:

HOSPITAL CARE		
Are you currently under hospital care?	Yes/No (If YES, then complete details BELOW)	
Hospital Name	Name of Consultant	Nature of problem

Your Weight	Your Height

DO YOU CURRENTLY SMOKE?			
How many cigarettes per day		How many ounces of tobacco per week	
Would you like to receive information on how you can get support to stop smoking	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
DID YOU EVER SMOKE?		If 'YES' when did you quit?	

VACCINATIONS	
Have you had a 'flu vaccination? Please enter year	
Have you had a pneumococcal vaccination? Please enter yea	

REPEAT MEDICATION	
Any known allergies that you have	Please specify
Are you on any repeated medication	YES <input type="checkbox"/> NO <input type="checkbox"/>

IF YES, PLEASE PROVIDE US WITH MOST RECENT REPEAT PRESCRIPTION SLIP or PROOF OF YOUR CURRENT MEDICATION FROM YOUR PREVIOUS GP. THIS WILL ENABLE US TO UP-DATE YOUR MEDICAL RECORDS TO ENSURE A PRESCRIPTION IS READY FOR YOU WHEN YOU REQUIRE ONE

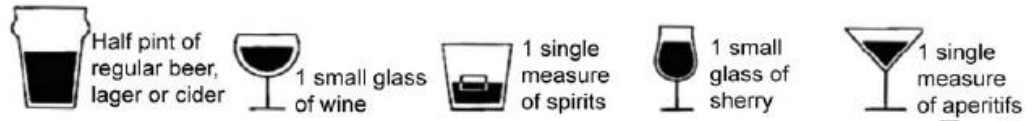
I have attached my repeat prescription: Please TICK if you have

If you do not have a repeat prescription form, please ask the receptionist for a **MEDICATION FORM** that you can complete so that we may obtain this information from your previous GP

WOULD YOU LIKE TO SIGN UP FOR OUR TEXT MESSAGING SERVICE AND ALLOW US TO SEND YOU A REMINDER FOR ANY SCHEDULED APPOINTMENTS YOU HAVE AT THE PRACTICE?
YES <input type="checkbox"/> NO <input type="checkbox"/>

ALCOHOL CONSUMPTION Name..... D.O.B.....

This is one unit of alcohol...



...and each of these is more than one unit



AUDIT – C	Scoring system					Your score
	0	1	2	3	4	
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	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.

TOTAL OF FIRST 3 QUESTIONS



Remaining AUDIT questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

A score of 16 or above indicates that you may be at higher risk from drinking alcohol
Total Score equals = Totals for first 3 questions and remaining 7 questions



REDGATE MEDICAL CENTRE

PATIENT ON-LINE ACCESS REGISTRATION

You can now register to **order repeat prescriptions, arrange a GP appointment and view certain aspects of your medical record online.** This will include details of your current medications, any allergies or adverse reactions that you have had and any previous immunisations. In the future you will be able to access your test results and more detailed information about your medical history as well.

Access to your online medical records will be granted on a patient by patient basis following receipt of an application form and confirmation of your identity. One of these needs to include a photograph of you. Acceptable documents include Passport, Photo Driving license and Bank Statements or Utility Bills.

Please note that Online Access to Medical Records is only granted to patients of 18 years and over.

I have read and fully understand what Patient-on-line access is and would like to apply.

Application for Online Access to my Medical Record

Surname (PLEASE PRINT)	Date of birth
First name (PLEASE PRINT)	
Address (PLEASE PRINT)	
Postcode	
Email address	
Telephone number	Mobile number

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	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>
YOUR PERSONAL PASSWORD WILL BE AVAILABLE TO COLLECT FROM THE PRACTICE FOLLOWING REGISTRATION WHICH WILL BE COMPLETED WITHIN ONE WEEK OF RECEIPT OF THIS QUESTIONNAIRE	<input type="checkbox"/>

Patient Signature	Date
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For practice use only

Patient NHS number		
Identity verified by (initials)	Date	Method Photo ID and proof of residence <input type="checkbox"/>
Notes / explanation		
Date account created:		
Read codes:		
#93440. authorised by:	added by:	date:
#91B. authorised by:	added by:	date:

Redgate Medical Centre offers its patients the choice of having a Summary Care Record. The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- Any allergies you may have
- Unexpected reactions to medications
- And any prescriptions you have recently received

The intention is to help clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you are happy for a Summary Care Record to be set up for you then you need take no further action. If you want to opt-out now please tick the box below and return it to Reception within the next three days.

Please tick the box and sign below:

No I do not want a Summary Care Record Yes I want a Summary Care Record

Signed _____ Date _____

HealthSpace information

In addition, patients over 16 can register on a secure website called HealthSpace for a 'Basic' account which gives you access to a Personal Health Organiser. Register at www.healthspace.nhs.uk to do this. If you go a stage further you can register for an 'Advanced' account which will entitle you to see a copy of your Summary Care Record once it has been created. Complete the Advanced Registration application and print off the form and contact your Patients' Advice and Liaison Service (PALS) office to find out where you should go to register for an Advanced HealthSpace Account. You can do this by emailing healthspace@somerset.nhs.uk or by telephoning the PALS on **0800 0851 067**. Advisers are available Monday to Friday from 9.00am to 5.00pm.

YOUR FULL NAME: _____ **DATE OF BIRTH:** _____

How much is too much? Simple Structured Advice



UNITS



Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

Remember, drinks poured at home are usually bigger

Are you at risk from drinking alcohol?

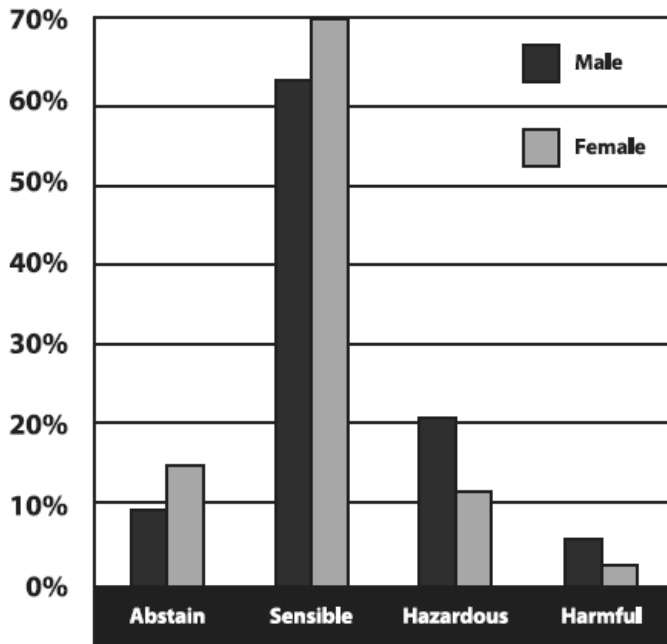
Risk	AUDIT Score	Men	Women	Common Effects
SENSIBLE	0 - 7	21 units or fewer per week or up to 4 units per day	14 units or fewer per week or up to 3 units per day	<ul style="list-style-type: none"> • Increased relaxation • Reduced risk of heart disease • Sociability
HAZARDOUS (risky drinking)	8 - 15	22 - 49 units per week or regular drinking of more than 4 units per day	15 - 35 units per week or regular drinking of more than 3 units per day	<ul style="list-style-type: none"> • Less energy • Depression/Stress • Insomnia • Impotence • Risk of injury • High blood pressure • Relationship problems • Increased risk interfering with medication
HARMFUL (very risky drinking)	16 - 19	50 + units per week	36 + units per week	<ul style="list-style-type: none"> • All of the above and... • Memory loss • Increased risk of liver disease • Increased risk of cancer • Possible alcohol dependence

- Binge drinking is considered to be drinking twice the daily limit in one sitting (8+ units for men, 6+ units for women).
- There are times when you will be at risk even after two or three drinks. For example, when exercising, operating heavy machinery, driving or if you are on certain medication.
- If you are pregnant it is recommended that you completely abstain from drinking alcohol.
- As well as keeping to weekly and daily limits it is recommended that 2 days of the week should be alcohol-free.

Your screening outcome is

How do you feel?

What is everyone else like?



Most people are sensible drinkers

What are the benefits of cutting down?

Physical

- Reduced risk of injury
- Reduced risk of high blood pressure
- Reduced risk of cancer
- Reduced risk of liver disease
- Reduced risk of brain damage
- Sleep better
- More energy
- Lose weight / Better physical shape
- No hangovers
- Improved memory

Psychological/Social/Financial

- Improved mood
- Less hassle from family
- Reduced risk of drink driving
- Save money
- Better relationships

Making your plan

- Have your first alcoholic drink after starting to eat
- Quench your thirst with non-alcoholic drinks before alcohol
- Avoid salty snacks when drinking alcohol
- Avoid drinking in rounds or in large groups
- Switch to low alcohol beer/lager
- Take smaller sips
- Plan activities and tasks at those times you usually drink
- When bored or stressed have a workout instead of drinking
- Explore interests - cinema, exercise, etc.
- Avoid going to the pub after work
- Avoid or limit the time spent with 'heavy' drinking friends
- Any ideas? - Things you have tried?

What targets should you aim for?

'How to do it' - the ideal

Men

4 or less standard drinks daily
21 or less standard drinks weekly

Women

3 or less standard drinks daily
14 or less standard drinks weekly
No drinks advised during pregnancy

Dependent Drinkers

No drinks are safe

Your first achievable step

What is your target?

**Remember, nobody's perfect!
If at first you don't succeed,
try again.**

