Atrium Health Centre

www.atriumhealth.nhs.uk

Dear New Patient

Welcome to the Atrium Health Centre and thank you for choosing to register with us.

Our surgery exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website; **www.atriumhealth.nhs.uk** and our practice leaflet (please ask at reception if you would like a leaflet).

As a new patient we would ask that you complete the attached New Patient Questionnaire fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background. **We ask that you also provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). Please note your registration cannot be accepted until the forms are completed in full, with all requested details and the form is signed and dated.** All information provided is treated in the strictest confidence and only shared with relevant clinicians and medical staff and is not shared with any third party (unless medically necessary and\or agreed). We will also only contact you via the information you supply only for the purpose of your medical care.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional within the next 48hours. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or our Patient Services Manager and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service or fax machine.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully

Lisa Fall
Practice Business Manager

7 Weymouth Avenue Dorchester DT1 1QR
T: 01305 251545 email; atrium.reception@nhs.net

Old Farm Way Crossways Dorchester DT2 8TU
T: 01305 854355 email; atrium.reception@nhs.net

Dr Sian Griffiths
BM DRCOG

Dr Andrew Allen
MB ChB MRCGP DCH

Dr Laura Morgan
BM MRCGP

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Personal Details:	
Title	
Surname	
Given Name	
Middle Name(s)	
Known As	
Previous Surname (if applicable)	
Date of Birth	
NHS Number	
Gender	☐ Male ☐ Female
Home Address:	
House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode	
Previous Home Address:	
House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode	
Contact Details:	
Home Telephone	
Work Telephone	
Mobile Telephone	
Do you consent to us contacting you by text (SMS)	☐ Yes ☐ No ☐ Please tick if preferred communication method
Email Address	
Do you consent to us contacting you by email	☐ Yes ☐ No ☐ Please tick if preferred communication method
Next of Kin Details;	
Next of Kin Name	
Relationship	
Telephone Number	
Please help us trace your previous medical records by providing the following:	
Name & Address of last GP	
Background Details;	
Town + Country of Birth	
Ethnicity	☐ British ☐ African ☐ Bangladeshi ☐ Caribbean ☐ Chinese ☐ Indian ☐ Irish ☐ Other White ☐ Other Asian ☐ Other Black ☐ Other Mixed ☐ White Asian ☐ Pakistani ☐ W&B African ☐ W&B Caribbean ☐ Refuse to Divulge

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IF YOU ARE FROM ABROAD:		
Date of entry into the UK		
Are you a visitor?	☐ Yes	☐ No
Are you a UK passport holder?	☐ Yes	☐ No
Do you hold an EHIC? (European Health Insurance Card)	☐ Yes	☐ No

IF YOU ARE RETURNING FROM THE ARMED FORCES:			
Address before enlisting			
Service or Personnel no;			
Enlistment Date		Date of Leaving	

COMMUNICATION NEEDS:			
Main Language			
Interpreter Required?	☐ Yes	☐ No	
Do You have any special Communication Needs?	☐ Yes	☐ No	
If 'Yes'	☐ Sign Language	☐ Large Print	☐ Other; ....

Accessible Information: If you have stated that you have any special communication needs on this form we will do our best to accommodate your needs. Should your needs change please inform us.

CARERS:				
If you are a Carer would you like to be added to the Practice's register\give consent to receive regular information and meeting dates	☐ YES	☐ NO		
(If yes) I care for (name):				
Relationship to you:				
The person I care for has:	☐ Dementia	☐ Physical Disability	☐ Mental Illness	☐ Chronic Disease

ALLERGIES:		
Do you have any Allergies? (e.g. antibiotics, food, bee sting, latex)	☐ YES (Please state);	☐ NO

HEALTH INFORMATION:

How often do you have a drink containing alcohol?	Never		Less than Monthly	2 – 3 times a Month	2 – 3 times a Week	4 or more times a week
How many units of alcohol do you drink on a typical day when you are drinking?	N\A	1or 2	3 or 4	5 or 6	7 or 9	10 or more
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

Smoking Status: (please tick one box only)

☐ I am a Smoker (including e-cigarettes)

(For help to stop smoking phone 0800 007 6653 or visit ww.nhs.uk/smokefree)

☐ I have never smoked ☐ I am an ex-smoker; Date quit:

BP (if known)			
Weight (st\lbs or Kgs)		Height (ft\" or metres)	

LADIES: Are you currently Pregnant? ☐ YES ☐ NO

If you are pregnant please provide estimated delivery date:

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CURRENT MEDICATION:		
If you have a repeat medication slip from your previous GP please attach to this form.		
Electronic Prescription Service: Under NHS guidelines we use electronic prescribing in the practice and send all prescriptions direct to your pharmacy. Therefore please let us know the local pharmacy that you will be using:		
PRACTICE SERVICES\GROUPS:		
Would you be interested in joining the Practice Patient Participation Group?	☐ YES	☐ NO
Do you wish to register for online services? This will enable you to request prescriptions, book appointments, view your summary care record and your medical record.	☐ YES	☐ NO

NHS DONOR REGISTRATION:		
I wish to register my details on the NHS Organ donor\the NHs Blood Donor register(s) as someone whose organs \tissue may be used for transplantation after my death &\or who may be contacted and would be prepared to give blood. For more information visit www.uktransplant.org.uk. I would like to donate: (Please tick all boxes that apply)		
☐ Any of my organs & tissue **or;**	☐ Any part of my body **or;**	
☐ Heart only	☐ Liver only	☐ Corneas only
☐ Kidneys only	☐ Lungs only	☐ Pancreas only
I would like to join the Blood donor register;	☐ Yes	☐ No
I have given Blood in the last 3 years;	☐ Yes	☐ No
Signature confirming consent\ agreement of items ticked above;		

RECORD SHARING:		
Do you consent to the sharing of relevant medical information recorded by the practice with any other organisations that may provide medical care to you?	☐ YES	☐ NO
Do you consent to the practice viewing data that is recorded about by other organisations that may provide medical care to you? (if you have agreed to them sharing your data)	☐ YES	☐ NO
ENHANCED SUMMARY CARE RECORD:		
Do you consent to your **basic** medical information (i.e. Medication you are taking and any allergic reactions) to be shared for any medical professional to see in the event of you needing care in another part of the country?	☐ YES	☐ NO
Do you consent to your **enhanced** medical information (i.e. your long term health conditions, any relevant medical history, your health care preferences, immunisations, Medication you are taken and any allergic reactions) to be shared for any medical professional to see in the event of you needing care in another part of the country?	☐ YES	☐ NO

OTHER INFORMATION\PATIENT CONFIRMATION:

Declaration: By providing the information on this form and signing below, you are consenting to be contacted about your medical needs by the practice in accordance with the General Data Protection Regulations via any of the methods you have provided on this form.
Also by completing and signing this form you are agreeing to abide by the details in the Atrium Patient Contract and Zero tolerance Policy (copies of which can be found on the practice website or requested from Reception).
If any of the details on this form change in the future it is your responsibility to inform us.

Signed: (Patient\on behalf of patient)	Date:

RECEPTION ONLY (WHEN ACCEPTING FORM):		
Type of ID Seen:	1.	2.
Form fully checked & ID Seen by:		

WHEN REGISTERING PATIENT:					
Registered by (name):					
Patient checked for existing record on SystmOne?				☐ YES	☐ NO
GP Allocated:	☐ YES	☐ NO	Patient informed:	☐ YES	☐ NO
PIN document for Online access printed\given to patient where applicable				☐ YES	☐ NO
Is patient to be registered as Out of Area?				☐ YES	☐ NO
If yes; Has patient been given out of area letter to sign?				☐ YES	☐ NO