QUESTIONNAIRE ATTACHED FOR COMPLETION

MUST PROVIDE H&C NUMBER

INFORMATION FOR PATIENTS WHEN REQUESTING REGISTRATION

- IF YOU HAVE ATTENDED ANOTHER PRACTICE BEFORE COMING TO US AND WERE REFUSED REGISTRATION OR TREATMENT, YOU SHOULD BE AWARE THAT AN EXPLANATION FOR THIS SHOULD BE GIVEN TO YOU IN WRITING BY THAT PRACTICE. YOU ARE ADVISED TO RETURN TO THAT PRACTICE AND REQUEST A WRITTEN EXPLANATION.

- IF YOUR ADDRESS IS STILL WITHIN YOUR CURRENT PRACTICE'S CATCHMENT AREA, THAT PRACTICE WILL CONTINUE TO BE RESPONSIBLE FOR YOU UNTIL YOUR REGISTRATION PROCESS IS COMPLETED HERE AND YOUR CURRENT PRACTICE HAS BEEN NOTIFIED THAT YOU HAVE TRANSFERRED FROM THEIR LIST TO OUR LIST. **THIS CAN TAKE 2-3 WEEKS.**

BENZODIAZEPINES, (DIAZEPAM, TEMAZEPAM, NITRAZEPAM, ZOPICLONE, CO-CODAMOL ETC)

- THE PRACTICE IS PARTICIPATING IN A BENZODIAZEPINE REDUCTION PROGRAMME ALONG WITH OTHER PRACTICES IN NORTH AND WEST BELFAST. **IF YOU ARE CURRENTLY ON BENZODIAZEPINE MEDICATION THIS WILL BE REDUCED AND THEN STOPPED. AGAIN, NO MEDICATIONS WILL BE SUPPLIED WITHOUT WRITTEN CONFIRMATION FROM YOUR CURRENT GP.**

OTHER MEDICATIONS WE DO NOT PRESCRIBE

- All Sleeping Tablets
- Lyrica (Pregabalin)
- Tramadol
- DHC (Dihydrocodeine)
- **Co-Codamol 15/500mg**
- **Co-Codamol 30/500mg**
- Codeine

Minor ailments such as coughs, colds & thrush, there are a number of items available at your local pharmacy under the 'minor ailments scheme' please see attached information leaflet.

Normal enquiries and appointment requests and **urgent calls** can be dealt with by the receptionist. On these occasions it is necessary for the receptionist to ask about the nature of calls and their urgency, as the doctor is already consulting with a patient. It is the patient's responsibility to call back later that day for a reply to their enquiry

ZERO TOLERANCE POLICY

- **THE PRACTICE OPERATES A ZERO TOLERANCE POLICY AND ANYONE USING FOUL, THREATENING OR INTIMIDATING LANGUAGE OR BEHAVIOUR TO ANY MEMBERS OF THE PRACTICE WILL BE REMOVED FROM THE PRACTICE LIST IMMEDIATELY.**

This Practice operates a Zero Tolerance Policy and anyone using abusive, foul, threatening or intimidating language or behaviour to any members of Practice Staff, will be REMOVED from the Practice list immediately.

PLEASE MAKE YOURSELF AWARE OF THE PRACTICE'S DNA POLICY THERE ARE POSTERS IN THE WAITING AREA

- FAILURE TO ATTEND FOR 3 APPOINTMENTS WITHIN A 12 MONTH PERIOD MAY RESULT IN REMOVAL FROM THE PRACTICE LIST

- CANCELLATIONS ARE VITAL TO THE DAILY RUNNING OF THE SURGERY; THERE IS ALWAYS SOMEONE IN NEED OF AN APPOINTMENT. PLEASE BE CONSIDERATE OF YOUR FELLOW PATIENTS.

Please sign declaration below which will be kept in your clinical record.

I _____

Of_____

H+C NO_____

Agree to the above terms of the practice. I acknowledge that certain medications will not be prescribed by the Practice and recognise and understand the Practice Zero Tolerance Policy.

Print Name: _____Signed:_____ Date _____

New Patient Questionnaire

(ALL sections of this form MUST be COMPLETED)

Section 1 - Personal Details

(Please write clearly)

Title Mr □ Mrs □ Miss □ Ms □ Other □ (please specify) _____

Name ..... Date of Birth .....

Town of Birth ..... Country of Birth .....

If Applicable (for those born outside the UK)

Reason for coming to UK..... Date of entry to the UK .....

Section 2 – Contact Details

Address..... .....

.....

Telephone number(s) ..... Mobile .....

How long have you lived at this address .....

Is this your permanent address? ....

Section 3- Ethnic Origin

White □ Black other □ Chinese .....□

Black Caribbean □ Pakistani □ Vietnamese .....□

Black African □ Bangladeshi□ Indian □

Other .....

What is your main spoken language? .....

Do you require an interpreter? (Please circle which is appropriate)

Yes No

Section 4 – Current GP Details

Name and address of your Current GP... .....

.....

Reason for changing doctor?..... .....

.....

.....

Section 5 – Family

Do you have any family members registered with the practice?

Yes/ No

Please give details of those family members.....

....

....

Who is your next of Kin?

Name .....

Relationship .....

Contact number .....

Are you: A Carer?

- **A Carer –** (someone who looks after family, partners, friends or neighbours in need of help because they are ill, frail or have a disability.) **Yes/No**

If you answered yes please give details of the person you care for and your relationship with them..... .....

.....

<u>Section 6 – Medical History</u>

Do you suffer from any of the following illnesses?

(*Please circle which is appropriate)*

Heart Disease	Yes/No	Stroke/TIA	Yes/No
Hypertension	Yes/No	Diabetes	Yes/No
Epilepsy	Yes/No	Hypothyroidism	Yes/No
Asthma	Yes/No	Depression	Yes/No
Dementia	Yes/No	Osteoporosis	Yes/No
Rheumatoid Arthritis	Yes/No	Chronic Kidney Disease	Yes/No

Peripheral Arterial Disease Yes/No

Chronic Obstructive Pulmonary Disease (COPD) Yes/No

Cancer Yes/No Please specify .....

Other (please give details) .....

Do you have any allergies? ..... Yes/No

If you answered yes please give details of the allergy .....

.....

.....

What is your smoking status? (*Please circle)*

- Never Smoked
- A Smoker How many per day _____
- Ex-Smoker When did you stop? _____

Do you Drink Alcohol? …… Yes/No

If you answered YES how often do you drink Alcohol? .....

(1 Pint of Beer = 2.3 Units, or 1 small glass of wine = 2.3 units, or 1 measure of spirits = 1 unit)

Using the above information as guide how many units of alcohol would you normally drink? .....

Section 7 – Current Medication

Please list all current medication: ***This list will be confirmed by your current GP.***

Drug Name	***Strength***	***Dose***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ Date_____

PLEASE ENSURE YOU ARE PROVIDED WITH A PRACTICE INFORMATION LEAFLET BEFORE YOU LEAVE.

Think before you ask!

Many minor ailments can be treated through your local Pharmacy's MINOR AILMENTS SCHEME or by buying medicine from the pharmacy.

Treatments FREE OF COST include:

- **Cold sore cream**
- **Head lice treatment**
- **Oral thrush, mouth ulcers or sore gums**
- **Vaginal thrush**
- **Occasional diarrhoea**
- **Athlete's foot**
- **Threadworms**
- **Ear wax**

Treatments will no longer be prescribed, but can be purchased to treat:

- **Coughs, colds and sore throats**
- **Mild heartburn and indigestion**
- **Occasional constipation**
- **Headaches**
- **Aches and pains**
- **Haemorrhoids (piles)**
- **Nappy rash and teething**

155 Andersonstown Road
BELFAST
BT11 9EA
028 90 611411

Dr M O'Donnell Dr Paula Coyle

CONSENT FORM

I, _____, DOB _____ give

permission for a summary of medical notes to be released

to_____, for the purposes of registration.

I do/do* not wish to see the notes before they are released (*Please

delete)

Patient's Signature Date

_____

_____

Information requested should include:

- Last 3 patient consultations
- Current Medications (Acute & Repeat)
- Medical Problems
- Allergies

Signed on behalf of Willow Medical Practice

Pauline McCullough
Practice Manager

H&C: number: _____

If you do not know your health & care number (H&C), please contact your **current GP** for this.

Please do NOT return this form **without** a H&C number.

Without this we cannot

- register you,
- Do any needed referrals,
- Do any blood test or other tests.

Please return filled form to the surgery in person, by post or by email, along with copies of **proof of address** and **photo ID. (**You must provide your own copies due to covid-19) **.**

Pictures of same can be emailed.

Address:

Willow Medical practice

Unit 2

155 Andersonstown Rd

Belfast

BT119EA

Email:

reception.z00063@gp.hscni.net