

DEVENISH PRACTICE

PATIENT INFORMATION TO REGISTER WITH THE PRACTICE

Welcome to Devenish Practice, our policy is to accept new patients to the practice if they meet the criteria listed below:

- New patients must reside within a 6 mile radius of the practice; this will be determined using postcodes and Bing maps.
- Returning patients e.g. Students returning from university may re-join the practice if their family are still patients of the practice.

All new patients must produce a medical card or complete a HS200 form if they have been registered with a GP in the UK previously and have lost or mislaid their card. If you have never been registered with a doctor in the UK you will need to complete a HS22X form in addition to completing the questionnaire below. This questionnaire can be used to capture data for new patient registrations and will also help to establish a base-line view of the patient life-style and will assist the nurse / doctor in carrying out a new patient health check. The information provided will assist also in the identification of "at risk" patients and focus care advice on at risk areas.

Patients must also bring photographic identification preferably with their current address on it otherwise a utility bill or other form of proof of address should also be brought to the practice when returning the forms to the practice.

Your completed application will go to a practice meeting held on Wednesday morning when we have all the necessary forms fully completed and the necessary documentation. If your application is successful you will be contacted to arrange a new patient review appointment with our practice nurse or our healthcare assistant. Please bring a sample of urine to the appointment.

If you are unable to attend your appointment you must contact the surgery to reschedule and free the appointment for another patient. Failure to cancel appointments in a timely manner may result in your application being rejected, or at a later day you could be removed from the practice list.

It is very important if you are also registering that we have a detailed record of all your children's immunisations and any significant health issues.

DEVENISH PRACTICE
NEW PATIENT QUESTIONNAIRE

THIS FORM MUST BE COMPLETED BEFORE ANY APPOINTMENT CAN BE OFFERED (please tick answers as appropriate and complete FULL questionnaire)

This information is strictly confidential

Patient's Name _____ DOB _____

Address _____

Post Code _____ Place of Birth _____

Telephone (Home) _____ (Mobile) _____ (Work) _____

Previous GP Name _____ Previous GP Tel No _____

Address of Previous GP _____

Next of Kin

Name _____ Relationship to you _____

Address _____

Tel No _____

Do you currently suffer from any of the following conditions? Please tick as appropriate:

Heart Disease/Heart Failure	[]	Stroke or TIA	[]
Hypertension	[]	Diabetes	[]
COPD (Lung Disease)	[]	Epilepsy	[]
Hypothyroidism	[]	Cancer	[]
Asthma	[]	Depression/ Mental Health	[]
Atrial Fibrillation	[]	Kidney Disease	[]

Do you take any Repeat Medication? Please specify your Repeat Items and reason for prescription.

Do you have a sensory Impairment? YES/NO

Hearing Impairment [] Deaf [] Partially Sighted [] Blind []

Any drug allergies: YES/NO if yes, name of drug: _____

Reaction Type: Allergy [] Intolerance []
Severity: Mild [] Moderate [] Severe []

Any operations: Please state date and type

Any past illnesses:

1. TB	[]	2. Asthma	[]
3. Diabetes	[]	4. High Blood Pressure	[]
5. Jaundice	[]	6. Heart problem	[]
7. Glaucoma	[]	8. Cancer	[]

Any other major illness:

Date _____

Any family history:

1. TB	[]	2. Asthma	[]
3. Diabetes	[]	4. High Blood Pressure	[]
5. Jaundice	[]	6. Heart problem	[]
7. Glaucoma	[]	8. Cancer	[]

Do you drink alcohol? YES/NO (Amount per week) _____

Do you smoke/Have you ever smoked? (Details) _____

Do you exercise? Inactive [] Moderate [] Vigorous [] Gentle []

How would you describe your diet? Good [] Moderate []
Poor [] Vegetarian/ Vegan []

Food allergies: YES/NO if yes, name of food _____

Do you use any form of contraception? YES/NO What type: _____

Employment: Employed [] Unemployed [] Retired []
Part-time [] Full-time [] House Wife [] House Husband []

If employed job title _____

Do you need an interpreter? YES/NO Main Spoken Language _____

Any other problems you would like to discuss with the nurse: _____

This section is for women only:

Have you had a smear? YES/NO Date of last smear: _____ Result: _____

Do you wish to be **excluded** from Cervical Smear invites for the next 3 years? YES/NO

Signature: _____

All adult female patients will automatically be invited for Cervical Smear after 3 years.

This section is for patients who are carers.

Do you care for an elderly or sick relative? Yes [] No []

If your answer is yes, please tick if you would like to be referred for a carers assessment []

Erne Health Centre
Erne Road
(W8095)
Enniskillen
Co Fermanagh
BT74 6NN.

Devenish Practice (W563)
Drs Guette (W8049) & Toland
Telephone 02866 325638

NEW CHILDREN REGISTERED TO THE PRACTICE

Full Names	DOB	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Full Postal Address _____

_____ Postcode _____

Telephone Number _____ Mobile Number _____

Mothers Name _____ DOB _____

Fathers Name _____ DOB _____

Please complete and return to Devenish Practice who will forward on to:

Health Visitor Team
Margaret Barton
South West Acute Hospital
Enniskillen
Co Fermanagh

Please bring in child(ren)s red book or immunisation history and any significant medical history for us to copy for clinical records.