THE WALCOTE PRACTICE
WINCHESTER'S PRIVATE GP

Healthplan Application Form - Adults

If you have obtained a copy of this form online, please fill it in and bring it with you to your appointment at The Walcote Practice. Please do not return this form to us by email – we wish to guard your medical safety and privacy and therefore we request that you do not send personal medical details online. Thank you.

Date form completed:	

GENERAL INFORMATION			
Title:		First name and middle names:	
Surname:		Town and country of birth:	
Date of birth:		Sex (please circle):	M F
Marital Status:		Email address:	
Address (including flat no.):		Are you happy for us to contact you by email? Y N	
		Who else lives in this household?	
		Are you a carer for anyone (if yes, please state their name)? Y N Name:	
Postcode:		What is your main language?	Occupation and its location:
Home tel no:			
Work tel no:			
Mobile tel no:		Do you consent to allow The Walcote Practice to text you non clinical information and reminders to your mobile number? Y N	Ethnicity: *Please see the final page for further information*
Are you happy to have messages left on the following numbers? Home tel no: Y N Mobile tel no: Y N			
As a result of a sensory loss, impairment or disability, do you (and/or your carer) require information to be presented in any particular format or do you require any support to help us best communicate with you (and your carer)? Please explain how we can assist. *Please see the final page for further information.*			

EMERGENCY CONTACT DETAILS Tick here to allow The Walcote Practice to contact in case of emergency ☐	
Full name:	Address:
Relationship:	
Home tel:	
Mobile tel:	

HOW DID YOU FIND OUT ABOUT/DECIDE TO REGISTER WITH THE WALCOTE PRACTICE? (please tick)		
☐ Word of Mouth - from whom (eg a friend)?	☐ Advert - where?	☐ Other - where?

NHS/OVERSEAS GP (please also stay registered with your NHS GP in order to access out of hours services)	
GP name:	GP surgery name & address:
GP tel no:	
Your NHS number:	

Patient Name:	
Patient Date of Birth:	

MEDICAL HISTORY			
Do you have/have you had any of the following conditions? (please circle and also add approximate date of onset)			
High blood pressure	Y N Date:	Diabetes	Y N Date:
Heart disease: (angina/heart attack)	Y N Date:	COPD (emphysema)	Y N Date:
Epilepsy	Y N Date:	Stroke	Y N Date:
Asthma	Y N Date:	Cancer	Y N Date:
Thyroid problems	Y N Date:	Depression/ anxiety	Y N Date:

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had:	
	Date:
	Date:
	Date:
	Date:

Other ongoing health problems:

Have you had measles or been vaccinated against measles with a **full** course of MMR or measles vaccines?
Y N Please give details and dates:

Do you follow any special diet (eg, low fat, low sugar, weight reducing)?

Do you have any allergies? If yes, please give details.
Y N

Do you have a family history of any of the above conditions? Please give details and approximate age of onset (and age of death if appropriate).

Do any other illnesses run in your family? If yes, please give details.

Is anyone a carer for you? If yes, please give details.

What health outcomes would you most like to achieve through working with the doctors at The Walcote Practice?

Patient Name:	
Patient Date of Birth:	

MEDICATION	
Are you on any regular medication (including the contraceptive pill)?	Y N
If yes, please state name, dose and number of times per day	
Are you allergic to any medicines?	Y N
If yes, please state type and name of medicine	

SMOKING HABIT				
Are you a current smoker? Y N	If Yes		If No	
	No. cigarettes per day		Have you ever smoked?	
	No. cigars per day		If yes, what year did you stop?	
	Pipe tobacco per week (oz/grams)		How many *did* you smoke per day?	
	Would you like help to stop?	Y N	Total number of years smoking?	

ALCOHOL INTAKE	
Do you drink alcohol?	Y N
If yes, wines/spirits: units per week	
If yes, beer: units per week	
1 unit = 1 small glass of wine OR 1 single measure of spirit OR 1 half pint (of standard strength) beer	

EXERCISE HABIT	
Do you take regular exercise?	Y N
If yes, what sort (eg, tennis, walking)?	
For how long at any one time?	
How many times weekly?	

WOMEN ONLY					
Date of last smear?		What was smear result?		Where was the smear taken?	
No. of pregnancies?		No. of children?		Are you pregnant now?	
Date of last mammogram (if applicable)		What was the mammogram result?		Method of contraception (if used)?	

FOR PRACTICE USE ONLY					
Date:		Height (cm):		Waist circ (cm):	
Completed by:		Weight (kg):		BP:	
Urinalysis:		BMI:		Blood sugar:	

Patient Name:	
Patient Date of Birth:	

Summary Fair Processing Notice (Patient Data)

When Walcote Health Ltd, the data controller, processes your personal data we are required to comply with data protection legislation, including the UK General Data Protection Regulation ('UK GDPR') and the Data Protection Act 2018, to ensure that your information is properly protected and used appropriately.

Your personal data includes all the information we hold that identifies you or is about you (eg, your name, address etc). It also includes sensitive information such as your ethnic origin, medical records etc.

Everything we do with your personal data counts as processing it, including collecting, storing, amending, transferring and deleting it.

We process your personal data in order to provide you with the services you have requested, to fulfil the contract we have entered into with you (where applicable), to respond to any queries or comments you submit, to correspond with you on a day to day basis and/or to meet legal obligations.

We process most of your information on the grounds of 'special categories of data processing for the purposes of medical diagnosis and the provision of health care or treatment', although other grounds may at times apply, such as public health.

We only transfer your personal data to the extent we need to and/or that you request. If you attend our branch surgery at Healthshare Clinic Winchester (HCW), your name may be shared with HCW for fire safety purposes. Additional personal data may be shared with HCW if you choose to be referred to HCW for any further investigations or health consultations. In both of these cases, HCW will act as a data processor. We do not transfer your personal data outside of the EEA.

As with NHS GP practices, and in accordance with Information Governance Alliance (IGA) guidelines, Walcote Health Ltd will retain your personal data for a standard period of 100 years after your last medical appointment with us. This is in case any queries or issues arise and for health, administrative and/or statutory reasons. Your information will be kept securely at all times.

You benefit from a number of rights with respect to the personal data we hold about you, depending upon the grounds on which we process your data and subject to exemptions. These include the right of access to and rectification of your personal data, the right to restrict or object to data processing, withdraw consent or be forgotten, the right to complain to the Information Commissioner's Office (ICO) and the right to data portability.

Our full Fair Processing Notice provides further details about the personal data we process, why we process it and how we process it. Please ask if you would like to view a copy, or visit www.thewalcotepractice.co.uk/useful-documents/ .

For any queries you may have, please contact our Privacy Officer or any other member of our team in person, by post, by emailing info@thewalcotepractice.co.uk or by calling 01962 828715.

Patient Identity Verification (Staff Use Only)

Patient Name: **Date of Birth:**
Address:

Type of Patient ID	Y/N	Form of ID Seen by Staff Member	Staff Signature	Staff Member Name	Date of ID Check
Photo ID Shown by Patient?					
Proof of Address Shown by Patient?					
Proof of D.O.B Shown by Patient?					

If Proof of ID was not submitted, was the patient reminded to bring these documents to their next appointment at The Walcote Practice? Y / N

****Virtual Patient Participation Group****

Patient Name:	
Patient Date of Birth:	

Your opinions are very important to us. We have set up a virtual Patient Participation Group and would like to involve a broad spectrum of our patients. Please tick here (and enter your email address on the front page) if you would like to join. This will enable you to help shape our services by answering a question or two sent by the practice infrequently via email. ☐

Ethnic Group

Please help us plan for the future healthcare of our population by providing information on your ethnicity.

Please insert the ethnicity code corresponding to your ethnic group into the box on the front page of this registration form. Please only use one code. Thank you.

White	British	WBRI
	Irish	WIRI
	Other White background	WOTH
Mixed	White and Black Caribbean	MWBC
	White and Black African	MWBA
	White and Asian	MWAS
	Other Mixed background	MOTH
Asian/Asian British	Indian	AIND
	Pakistani	APKN
	Bangladeshi	ABAN
	Other Asian background	AOTA
Black/Black British	Caribbean	BCRB
	African	BAFR
	Other Black background	BOTH
Other ethnic groups	Chinese	CHNE
	Middle Eastern	MESN
	Other ethnic group (please provide details on front of form if you wish)	OOTH
Decline to provide ethnic group		REFU

Information & Communication

We wish to make our services accessible to everyone, so please let us know how we can best communicate with you (and your carer). Good communication is crucial to healthcare. We do our utmost to provide support to patients with a sensory loss, impairment or disability through the use of:

- communication support
- alternative information formats

For example, we are able to:

- produce documents in large print, easy read or braille formats etc
- use text or email to send information or to book appointments, rather than call by phone, if this is preferable
- offer a portable hearing loop for use during clinic or home visits
- arrange support from an advocate or a communication professional, eg a British Sign Language interpreter