NEW PATIENT QUESTIONNAIRE

(For Nursing Home / Residential Home Residents)

Surname: …… Forenames: ……

Date of Birth: ……..

Name of Care Home: …….

NHS email: …….

Temporary or Permanent: …….

Name of Next of Kin:…….. Relationship to you: …….

Address: ……

……..

Telephone Number: …….

Consent to discuss medical matters with next of kin? Yes/No

Medical Problems: ……

……

……..

Are you under hospital consultant? Yes/No

If yes, Name of Consultant/Speciality:
……

Number of falls in the last 12 months: ……..

Smoking History: Non-Smoker / Current Smoker ……per day/Ex-Smoker since ……...

Alcohol History: Never/Rarely/Social How many units per per week? ……

Medications + doses: ……

……

……

Medication needed in dispersible/liquid form? Yes/No

Nominated Pharmacy: …….

Allergies: ……

NEW PATIENT QUESTIONNAIRE

(For Nursing Home / Residential Home Residents)

Blood Pressure: Lying/Standing: ……..……
Heart Rate: …… Is pulse regular? Yes/No:
Weight (kgs): …….. Height (cms): ……..
Mobility: Independent ☐ Stick ☐ Zimmer ☐ Wheelchair ☐ Bedbound ☐ Continence: ……
Are you able to make decisions for yourself? Yes/No
Reasons for needing Care Home Placement?
Any present complaint/problem GP needs to be aware of?
Is an URGENT assessment required? Yes / No (if yes, explain why)

Do you consent to us sharing your important medical information with the ambulance service/out of hours/district nurses etc. so that all services will know of your medical problems and so can provide you the best care at all times? (This information is shared via the Summary Care Record – please ask at the surgery for more information if required.)

Medication / Allergies: Yes / No
Past Medical History Yes / No
My preferences for care Yes / No

NEW PATIENT QUESTIONNAIRE

(For Nursing Home / Residential Home Residents)

Do you have a

DNACPR form	Yes / No / Not appropriate at this time
ReSPECT Form	Yes / No / Not appropriate at this time
Peace plan	Yes / No / Not appropriate at this time
Advanced Directive	Yes / No / Not appropriate at this time
Proxy access form	Yes / No

Lasting Power of Attorney for:

Health	Yes / No
Finance	Yes / No

Named LPA: …….. Relationship to you: …….

PLEASE ENSURE COPIES OF ANY OF THE ABOVE ARE INCLUDED WITH THE REGISTRATION DOCUMENTS SENT TO THE SURGERY

Patient's/Representatives' signature: …….

Print Name: …….

Date: ……..……

Checklist of documents to include for registration:

- GMS1 registration form ☐
- New Patient Questionnaire *(this document)* ☐

Scanned copy of:

- DNAR ☐
- ReSPECT ☐
- Advanced care plan ☐
- Discharge letter ☐
- MAR chart ☐