Beaconsfield Road Surgery
NEW PATIENT QUESTIONNAIRE
(For Nursing Home / Residential Home Residents)

Surname: …… Forenames: ……..……..

Date of Birth: ……..……..

Name of Care Home: ……

NHS email: ……

Permanent or Temporary(if temporary how long for): ……

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

Address: ……

……..

Telephone Number: ……

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

Any lasting power of attorney in place? 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: ……

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Allergies: ……..……
Blood Pressure: Lying/Standing: ……..……
Heart Rate: …… Is pulse regular? Yes/No:
Weight (kgs): …… Height (cms): ……..
Mobility: Independent ☐ Stick ☐ Zimmer ☐ Wheelchair ☐ Bedbound ☐ Any Continence?: ……
Do you have the capacity to make decisions about your care? Yes/No
Reasons for needing Care Home Placement?
Any present complaint/problem which the GP needs to be aware of?
Is an URGENT assessment required? Yes / No (if yes, explain why)
Have you been Covid swabbed? If so, when? What was the result? Positive/Negative

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CHECKLIST

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

Do you have a

DNACPR form	Yes / No
ReSPECT Form	Yes / No
Peace plan	Yes / No
Advanced Directive	Yes / No
Proxy access form	Yes / No

Lasting Power of Attorney for:

Health	Yes / No
Finance	Yes / No

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

Patient's/Representatives' signature: …….

Print Name: …….

Date: ……..……

Checklist for Beaconsfield only:

- GMS1 registration form ☐
- Scanned copy of
  - DNAR ☐
  - ReSPECT ☐
  - Advanced care plan ☐
  - Discharge letter ☐
  - MAR chart
- Lasting power of attorney ☐