CENTRAL SURGERY NEW PATIENT REGISTRATION

# PERSONAL DETAILS: Title: Master/Mr/Mrs/Ms/Miss

Surname: Given Name(s) :

Previous Surname:

Divorced Separated Widow Widower Single Married

Address: Date of Birth:

Place of Birth:

Post Code:

Home Tel No: Occupation:

Mobile No:

Work Tel No: Employment Status:

Email Address:

Can we contact you by Mobile and Email? Yes/No (please circle)

Ethnic Group: ………………………. Main Language Spoken…………………….

Religion:

Is an Interpreter Required? Yes/No (please circle)

**-**

Previous GP: Previous Address:

Reason for changing GP:

If you are new to this country – How long are you planning to stay in the UK? ………………..

# NEXT OF KIN DETAILS:

Surname: First Name:

Address:

Postcode: Relationship:

(Husband, Wife, Partner, etc)

Home Tel No:

Mobile No: Work Tel No:

Can we contact your next of kin in an emergency? Yes/No

Do you give permission for staff to discuss personal matters with your next of kin? Yes/No

# CARER DETAILS:

**Are you a Carer for anyone? Yes/No (If Yes, carer for ……………………………)**

# Do you have a Carer? Yes/No

(A carer is anyone who looks after you due to illness or disability and can be your husband/wife/daughter, any relative or even a friend/next door neighbour, etc)

Your carer(s) details:

Surname: First Name:

Address:

Postcode: Relationship:

(Husband, Wife, Friend, etc)

Home Tel No:

Mobile Tel No: Work Tel No:

Can we contact your carer(s) in an emergency? Yes/No

**HAVE YOU PREVIOUSLY SERVED IN THE ARMED FORCES? Yes/No**

**(Date ………………..)**

**HEALTH PROMOTION AND PREVENTATIVE CARE:**

Children: Are you up to date with Childhood Immunisations? Yes/No

Adults: Please list any holiday or Occupational Health Vaccinations

Females between the age of 25 and 65: Are you up to date with smears? Yes/No

When was your last smear? Where was this taken?

Are you currently pregnant? Yes/No If pregnant, due date: ...…………………

If you are using contraception, please specify: …………………………………………

Please note that this practice focuses on health education and preventative care and therefore encourages patients to take responsibility for their own healthcare by being up to date with childhood immunisations and cervical smears. Failure to take on this responsibility will result in removal from the practice list.

I accept responsibility for my own healthcare

working in partnership with the practice Signed: Date:

CURRENT MEDICATION:

ALLERGIES:

MEDICAL HISTORY:

Are you able to leave the house without assistance? Yes/No

**MILITARY VETERANS**

**ACCESS TO HEALTH SERVICES FOR MILITARY VETERANS – PRIORITY TREATMENT**

The Practice is fully supportive of the Department of Health in requesting that the NHS works closely with military services to ensure that the health needs of military veterans are given the appropriate priority.

If GP’s are aware of a patient’s veteran status they are asked to state this in any referral letter including if, in their clinical opinion, the condition may be related to military service. They will allocate the correct appointment priority based on the patient’s medical condition.

Where a clinician receiving the referral agrees that a veteran’s condition is likely to be service-related they are asked to prioritise veterans over other patients with the same level of clinical need. **Veteran’s will not be given priority over other patients with more urgent clinical needs.**  
If you are a veteran (defined as someone who has served at least one day in the UK Armed Forces) and you would like your status to be shown on your medical records please select from one of the below..

Member of armed forces

Officer, armed forces

Armed forces reservist

Military Veteran

History relating to Army Service

History relating to Royal Navy Service

History Relating to Royal Air Force Service

Other: (Please State) ……………………………………….

**Summary Care Record (SCR)**

**Please read attached information sheet provided**

***Please tick either Option 1 or Option 2***

Option 1 – I am in agreement for a Summary Care Record to be created

Option 2 – I have attached my Summary Care Opt out form

**Please complete and bring to your appointment**

**AUDIT – C**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly  or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

**SCORE**

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

**IF YOU SCORE 5+, PLEASE COMPLETE AUDIT QUESTIONS ON OTHER SHEET**

**AUDIT**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly  or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

**SCORE**

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

16 – 19 Higher risk, 20+ Possible dependenc

**Summary Care Record (SCR)**

The SCR is an electronic health record that can be accessed when you need urgent treatment from somebody other than your own GP eg at A and E, or the GP out of hours service.

SCRs contain information about the medicines you are taking, allergies you have and any bad reactions to medicines you have had in the past.

Your SCR will be available to authorized healthcare staff wherever and whenever you need treatment in England, and they will ask your permission before they look at it.

As a patient you have a choice:

* **Yes, I would like a Summary Care Record.** If you want a record you do not need to do anything further, one will be created for you when you register with the Practice. If you have opted out of having a record in the past but have now changed your mind, speak to the receptionist and they can organize for one to be created for you.
* **No, I do not want a Summary Care Record.** If you do not want a record, you need to fill in the Summary Care Record opt out form and hand it in to the Practice. You should do this even if you have already completed a form at your previous Practice. Opt out forms are available from the Practice or from [www.hscic.gov.uk/scr](http://www.hscic.gov.uk/scr).

You are free to change your decision at any time by informing your GP Practice.

Children under 16 will automatically have a SCR created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel they are old enough to understand, please tell them about SCRs and explain the options available to them.

For further information, please visit the Health and Social Care Information Website (see previous web address), or call them on 0300 303 5678.