

New Patient Registration

Additional Contact Information

Mobile or Work Telephone Number:.....

Email Address:

Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age? YES / NO

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for:

their address

In order that we may take into account a patient's culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices

- | | | | |
|-------------------------|--------------------------|------------------------|--------------------------|
| White British | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> |
| White Irish | <input type="checkbox"/> | Bangladeshi | <input type="checkbox"/> |
| White Other | <input type="checkbox"/> | Other Asian background | <input type="checkbox"/> |
| White & Black Caribbean | <input type="checkbox"/> | Black Caribbean | <input type="checkbox"/> |
| White & Black African | <input type="checkbox"/> | Black African | <input type="checkbox"/> |
| White & Asian | <input type="checkbox"/> | Other Black background | <input type="checkbox"/> |
| Other Mixed background | <input type="checkbox"/> | Chinese | <input type="checkbox"/> |
| Indian | <input type="checkbox"/> | Any Other | <input type="checkbox"/> |

Additional Information

Height:

Weight:

Are you taking any regular medication? Please list; (use additional sheet if req'd)

Summary Care Record (Please refer to additional information sheets)

Yes I would like a Summary Care Record – you do not need to do anything and a Summary Care Record will be created for you.

Undecided - enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff within 12 weeks. If you do nothing, after this time, we will assume that you are happy with these changes and create a Summary Care Record for you.

No I do not want a Summary Care Record – enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.

Smoking status- Over 16 yrs

Current Smoker → How many per day

Current Non-Smoker → Date/Year Stopped Smoking

Never Smoked Tobacco

Assistance During Appointments

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator

Deafness – require a sign language translator

Disability – require a carer

Female Patients only

In order that we can arrange the correct follow-up, please let us know if you are using either of the following contraceptive devices:-

IUCD (coil) Date of insertion.....

Implanon/Nexplanon Date of insertion.....

Do you live alone? **YES/ NO**

Please answer the following questions about your alcohol intake

AUDIT-C

Alcohol Screening Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
3. How often during the last year have you found that you were not able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

TOTAL SCORE

If your total score is more than five please turn over and answer some further questions about your alcohol intake.

AUDIT

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains 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 have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL SCORE

UNITS



**IDENTIFICATION DOCUMENTS REQUIRED WHEN
REGISTERING AS A NEW PATIENT**

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this.

**PROOF OF NAME
(One of the following)**

Birth Certificate
Marriage Certificate
Driving Licence (valid)*
Passport (Valid)*

**PROOF OF ADDRESS; MUST BE DATED WITHIN THE LAST 3
MONTHS
(One of the following)**

Utility Bill
Council Rent Book
Bank Statement
Credit Card Statement
Letter from Benefits Agency

***Please note if applying for Online Access to your medical
records, photo ID must be produced.**

Information for our patients.

**We're improving how we communicate with patients.
Please tell us if you need information in a different format or
need communication support.**



Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

Title Surname / Family name

Forename(s)

Address

Postcode Phone No Date of birth

NHS number (if known) Signature

B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name Your signature.....

Relationship to patient..... Date

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no

Date

Ref: 4705

Out of area registration:

New arrangements introduced from January 2015 give people greater choice when choosing a GP practice. Patients may approach any GP practice, even if they live outside the practice area, to see if they will be accepted on to the patient list.

GP practices have always had the ability to accept patients who live outside their practice area. Regardless of distance from the practice, the practice would still provide a home visit if clinically necessary.

The new arrangements mean GP practices now have the option to register patients who live outside the practice area but without any obligation to provide home visits.

Out of area registration (with or without home visits) is voluntary for GP practices meaning patients may be refused because they live out of area.

If your application is considered the GP practice will only register you without home visits **if it is clinically appropriate and practical in your individual case**. To do this we may:

- Ask you or the practice you are currently registered with questions about your health to help decide whether to register you in this way
- Ask you questions about why it is practical for you to attend this practice (for example, how many days during the week you would normally be able to attend)

If accepted, you will attend the practice and receive the full range of services provided as normal at the surgery. If you have an urgent care need and the surgery cannot help you at home we may ask you to call NHS 111 and they will put you in touch with a local service (this may be a face to face appointment with a local healthcare professional or a home visit where necessary).

We may decide that it is not in your best interests or practical for you to be registered in this way. In these circumstances we may offer you registration with home visits, for example:- if you live just outside the practice area or we may not register you and advise you should seek to register (or remain registered) with a more local practice.

If accepted, but your health needs change, we may review your registration to see if it would be more appropriate for you to be registered with a GP practice closer to your home.

This new arrangement only applies to GP practices and patients who live in England. For further information visit the NHS Choices website (www.nhs.uk)

Application for online access to my medical record

Surname	Date of birth
First name	
Address	
Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	<input type="checkbox"/>

Signature	Date
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For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled		Notes / explanation	
All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed coded record <input type="checkbox"/> Limited parts <input type="checkbox"/>			

FOR PRACTICE USE ONLY

	Checked By (Initials)
Registration Form completed and signed	
Ethnicity completed	
Alcohol Screening Questions completed	
Smoking Status completed	
SCR option selected (Opt-Out Form completed if dissent given)	
ID Verified and photocopied	
Given Named GP letter	
Check if requesting online access and if so sign to say you have seen ID	