**New Patient Registration Form**

Please complete all pages in full using block capitals

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| **1. Background Details** |

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| **Contact Details** | | | | | | | |
| Name |  | | | Gender | |  | |
| Address |  | | | Date of Birth | |  | |
| Home Telephone | |  | |
| Work Telephone | |  | |
| Email address | |  | |
| Mobile Telephone | I consent to be contacted\* by SMS on this number: | | | | | | |
| Email | I consent to be contacted\* by email at this address: | | | | | | |
| Next of Kin | Name: | | Tel: |  | Relationship: | |  |
| Family Registered With Us | |  | | | | | |

*\* It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.*

*We may contact you with appointment details, test results or health campaigns*

*If you do not consent to being contacted by SMS or Email, please tick here:  SMS  Email*

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| **Other Details** | | | | | |
| Previous GP | Name: | | Address: |  | |
| Country of Birth |  | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Housing | Own Home  Sheltered House | Residential Home  Nursing Home | | Housebound  Homeless | Refugee  Asylum Seeker |
| Employment | Employed  Self-employed | Student  Unemployed | | House husband  House wife | Carer  Retired |
| Overseas Visitor | Yes | European Health Insurance Card Held (please bring details with you) | | | |
| Armed Forces | Military Veteran | Family member | |  |  |

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| **Communication Needs** | | | |
| Language | What is your main spoken language?  Do you need an interpreter?  Yes  No | | |
| Communication | Do you have any communication needs?  Yes  No (If **Yes** please specify below) | | |
| Hearing aid  Lip reading | Large print  Braille | British Sign Language  Makaton Sign Language  Guide dog |

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| **Carer Details** | | | | | |
| **Are you** a carer? | Yes – Informal / Unpaid Carer | | Yes – Occupational / Paid Carer | | No |
| Do you **have** a carer? | Yes | Name\*: | Tel: | Relationship: | |

*\* Only add carer’s details if they give their consent to have these details stored on your medical record*

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| **2. Medical History** |

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| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High Blood Pressure | Diabetes  Kidney Disease  Stroke | Depression  Underactive Thyroid  Cancer- Type: |
| Any other conditions, operations or hospital admission details:  If you are currently under the care of a Hospital or Consultant outside our area, please tell us here: | | | |

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| **Family History** | | | |
| Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Asthma………………….  COPD………………...…  Epilepsy………………… | Heart Disease……….…  Stroke…………….……..  Blood Pressure………… | Diabetes………..………  Kidney Disease..………  Liver Disease..….…….. | Depression………..……  Thyroid…………..….…..  Cancer………………….. |
| Other: | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below |

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| **Current Medication** |
| If you are on current repeat medication, please provide us with a copy of your latest prescription with your list of repeat medications. We will review your medications and either add them on to your repeat list or arrange a medication review appointment with you. |

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| **3. Your Lifestyle** |

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| **Alcohol** |
| Please answer the following questions which are validated as screening tools for alcohol use: |

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| **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 |  |
| A score of **less than 5** indicates *lower risk drinking* | | | | | TOTAL: |  |

**Scores of 5 or more** requires the following 7 questions to be completed:

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| **AUDIT QUESTIONS**  (after completing 3 AUDIT-C questions above) | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 last year |  | Yes, during 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 last year |  | Yes, during last year |  |
|  | | | | | TOTAL: |  |

[](http://www.citsu.ie/alcohol-and-drug-awareness)

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| **3. Your Lifestyle - Continued** |

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| **Smoking** | | | |
| Do you smoke? | Never smoked | Ex-smoker | Yes |
| Do you use an e-Cigarette? | No | Ex-User | Yes |
| How many cigarettes did/do you smoke a day? | Less than one | 1-9 10-19 | 20-39  40+ |
| Would you like help to quit smoking? | Yes | No |  |
|  | For further information, please see: [www.nhs.uk/smokefree](http://www.nhs.uk/smokefree) | | |

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| **Height & Weight** | | | |
| Height |  | Weight |  |

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| **Women Only** | |
| Do you use any contraception? | Yes  No If needed, please book appointment. |
| Are you currently pregnant or think you may be? | Yes  No Expected due date: |

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| **Students Only** | | | |
| Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see [www.nhs.uk/Livewell/Studenthealth](http://www.nhs.uk/Livewell/Studenthealth) | | | |
| I am less than 24 years old and have had two doses of the MMR Vaccination | Yes | No | Unsure |
| I am less than 25 years old and have had a Meningitis C Vaccination | Yes | No | Unsure |

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| **4. Further Details** |

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| **Electronic Prescribing** | |
| If you would like your prescriptions to be sent electronically,  please provide details of the pharmacy you would like to use: | Pharmacy: |

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| **Patient Participation Group** | |
| Would you like to be involved in our Patient Participation Group? | Yes  No |

*We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.*

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| **Blood and Organ Donation** | |
| Blood Donation | I am already a blood donor  I wish to be a blood donor  I do not wish to be a blood donor |
| Organ Donation | I am already registered as a donor  I wish to be a donor – all body part  I wish to be a donor – for these body parts:  I do not wish to be a donor  To register: Online: [www.blood.co.uk/the-donation-process/recognising-donors](https://www.blood.co.uk/the-donation-process/recognising-donors)  Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card. |

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| **Signatures** | |
| Signature | I confirm that the information I have provided is true to the best of my knowledge.  Signed on behalf of patient |
| Name |  |
| Date |  |

**Checklist**

Please ensure the following are done and provided so that your registration can be completed successfully

|  |  |
| --- | --- |
|  | Completed & Signed Above Form |
|  | Completed & Signed GMS1 Form |
|  | Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card* |
|  | Proof of Address  *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months* |

**Practice Use Only**

|  |  |  |  |  |
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| Appointment | Required | Not Required |  |  |
| Photo ID | Passport | Driving licence | Identity card | Other |
| Proof of Address | Utility Bill | Council Tax | Bank Statement | Other |

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| **5. Sharing Your Health Record** |

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| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who provide care for you?  Yes *(recommended option)*  No, except in an emergency  No, never *(not recommended, please discuss this with your GP before ticking this option)*  Do you consent to your GP Practice viewing your health record from other organisations that provide care for you?  Yes *(recommended option)*  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having a Summary Care Record?  Yes *(recommended option)*  No  Do you consent to having an Enhanced Summary Care Record with Additional Information?  Yes *(recommended option)*  No |

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| **Signature** | |
| Signature |  |
|  | Signed on behalf of patient |
| Name |  |
| Date |  |

**Sharing Your Health Record**

**What is your health record?**

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

**Why is sharing important?**

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

* Sharing your contact details This will ensure you receive any medical appointments without delay
* Sharing your medical history This will ensure emergency services accurately assess you if needed
* Sharing your medication list This will ensure that you receive the most appropriate medication
* Sharing your allergies This will prevent you being given something to which you are allergic
* Sharing your test results This will prevent further unnecessary tests being required

**Is my health record secure?**

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

**Can I decide who I share my health record with?**

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

**Can I change my mind?**

Yes. You can change your mind at any time about sharing your health record, please just let us know.

**Can someone else consent on my behalf?**

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

**What about parental responsibility?**

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

**What is your Summary Care Record?**

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

**How is my personal information protected?**

<Organisation Details> will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information, please see: [www.nhs.uk/NHSEngland/thenhs/records](http://www.nhs.uk/NHSEngland/thenhs/records)

Please bring photographic proof of your identification in order for the registration process to be completed

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| **Signature** | |
| Signature |  |
| Name |  |
| Date |  |

**For Practice Use Only:**

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| Identity verified through  (tick all that apply) | Self Vouching  Vouching with information in record  Photo ID  Proof of residence  Professional Vouching | | |
| Name of Verifier |  | Date |  |
| Name of person who authorised and added to SystmOne |  | Date |  |
| Photocopied this page | Yes – Name: | | |
| Passed for scanning | Yes – Name: | | |