hurley group

FAMILY DOCTOR REGISTRATION SERVICES

ADULT

Dear patient

By answering the question on this form you will be helping us to deliver better services to you as an individual. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form fully. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, or have any queries regarding this form, please feel free to ask the reception team.

PLEASE WRITE IN CAPITAL LETTERS - Thank you for your help.

Mr □ Mrs □ Miss □ Ms □ Other □ **Male □ Female □**

Surname _____ **DOB**_____/____/_____

First Name(s) _____

Previous Surname_____ **NHS Number** _____

Home Address

_____

_____

Town and Country of Birth _____

Telephone Number: 020 _____ **Mobile Number** _____

Work Telephone Number: _____

E-mail Address *(this will only be used for surgery correspondence*_____

Are you housebound? Yes □ No □

Name of Next of Kin_____ **Contact Number**_____

Relationship to the person _____

Please help us to trace your previous medical records by providing the following information;

Previous Address in the UK

_____

_____

Name and Address of your previous doctor

_____

_____

If you are from abroad

Your first UK address where registered with a GP

_____

_____

Date you entered the UK _____

Employment Status
Please tick

Retired □ Student □ Unable to work □ Unemployed □ Employed as _____

If you have children of your own aged 16 years or under, please list their names and dates of birth below?

Names	Date of birth

NHS Organ Donor Registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

□ Any of my organs and tissue or

□ Kidneys □ Heart □ Liver □ Corneas □ Lungs □ Pancreas □ Any part of my body

Signature confirming my agreement to organ/tissue donation:

_____ **Date:**_____

NHS Blood Donor Registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years □

Signature confirming consent to inclusion on the NHS Blood Donor Register my agreement to organ/tissue donation:

_____ **Date:**_____

Are you a carer?

i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental heath problem or for any other reason?

Yes □ No □

Are you cared for?

i.e. Do you have a friend or relative who helps you live your day to day life?

Yes □ No □

If yes please give details of your carer's contact information: (please code **918G/ 918A/ 918H** if patient is a carer**)**

Name _____

Contact Number: _____

Ethnic Status, Nationality & Language

What is your country of birth?

What is your main spoken language?

What language do you prefer to read?

Do you need an interpreter or translator?

What is your Religon?

Please tell us your ethnic group by ticking the box

White British □
White Irish □
White Scottish □
White Welsh □
Gypsy or Irish Traveller □
Any other white background, please describe……..

Black or Black British □
African □
Caribbean □
Any other black background, please describe……..

Asian or Asian British □
Bangladeshi □
Indian □
Pakistani □

Chinese □
Vietnamese □
Arab □
Any other asian background, please describe……..

Mixed Background □
White & Asian □
White & Black African □
White & Black Caribbean □
Any other background, please describe ……..

Women's Health
(this next section is for women only)

Cervical Smears

Date Taken	At GP / Clinic	Results	Recall Date

Smoking

Never Smoked □ Non-Smoker □ Pipe □ Cigars □ Rolling Tobacco □
Current Smoker □ (if so how many per day) _____ Would you like us to help you stop yes/no
Ex-smoker □ (if so how many did you smoke per day) _____ and the date you stopped _____

HIV SCREENING: Have you been screened for HIV? If YES, please give date screened _____

If NO, would you like to be screened? YES / NO

HEIGHT **WEIGHT** **BMI**

BP READING /

Do you have any allergies?

Medication	Food	Anything Else

Family History

Please let us know in this section of any illness that is in your family:

Disease	Relative
Heart Disease	
Stroke	
Hypertension	
Diabetes Type 1 or Type 2	
Asthma	
Cancer	
Any other	

Do you give your consent to have your medical records shared on the National Data Base? **Yes / No**
If you wish to opt out you must do so by calling **0300 303 5678 or** online via - https://your-data-matters.service.nhs.uk/
Info - https://www.nhs.uk/your-nhs-data-matters/manage-your-choice/

Accessible Information

Do you have difficulty hearing, or need hearing aids, or need to lip-read what people say? □ Yes □ No
Do you have difficulty with memory or ability to concentrate, learn or understand? □ Yes □ No
Do you have any special communication requirements/require specific communication support?
□ Sign language □ British Sign Language □ Makaton sign language □ Tadoma sign language
□ Lip reading □ Manual or electronic note taker □ Speech to text reporter □ Deafblind intervener
□ Loop system □ Other _____

What is the best way to send you information? □ Telephone □ SMS □ Letter □ Email □ Other: _____

Do you need a format other than standard print? □ Braille □ Easy Read □ Large print e.g. at least 20 point font
□ Electronic audio format e.g. MP3 or disk □ Other: _____

Do you need an assistance of Communication Professional? □ Interpreter for Deafblind People □ BSL Interpreter □ Makaton interpreter □ Tadoma interpreter □ Lipspeaker □ Notetaker □ Sign Language Translator □ Speech to Text Reporter □ Other_____

Do you give your consent to have a <u>Summary Care Record?</u> **Yes / No**
Your summary care record is a copy of key information held in your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you when you need unplanned care or when your GP surgery is closed. This information is accessed by NHS Accident & Emergency departments, Walk-in Centres and Out of Hours GP's. Healthcare staff are able to have quicker access to any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had. ***(Please code 9Ndo = No / 9Ndm = Yes)***
FORM - https://digital.nhs.uk/services/summary-care-records-scr/scr-patient-consent-preference-form
INFO - https://digital.nhs.uk/services/summary-care-records-scr

Thank you for taking time to complete this form.

Please ask at reception for a practice leaflet to explain the services we offer at our Practice

SIGNED: _____

DATE: _____

PATIENT DECLARATION

Anybody in England can register with a GP practice and receive free medical care from that practice.

The NHS is the UK's state health service which provides treatment for UK residents. Some services are free, other have to be paid for.

A person who is regarded as ordinarily resident in the UK is eligible for free treatment by a GP. A person is 'ordinarily resident' for this purpose if lawfully living in the UK for a settled purpose as part of the regular order of his or her life for the time being. Anyone coming to live in this country would qualify as ordinarily resident. Overseas visitors to the UK are not regarded as ordinarily resident if they do not meet this description. If you are not a 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

☐ **I confirm that I reside in the UK and am entitled to receive FREE NHS Treatment**

I declare that the information I give on this form is correct. I understand that if it is not correct, appropriate action may be taken against me

Signed:	Date
Print name:	

STAFF ONLY

PATIENT'S EMIS NUMBER:

REGISTRATION FORM CHECKED BY:_____

REGISTRATION FORM ENTERED ON SCREEN BY:_____

DATE ENTERED ON SCREEN_____

Alcohol Screening

Based on 1 unit = ½ pint of beer or 1 glass of wine (125 ml) or 1 single spirits How many units of Alcohol do you drink per week						**Score** ……
Questions	**Scoring System** 0	1	2	3	4	
How often did you drink alcohol in past year	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	……..
How many standard alcoholic drinks do you have on a typical day when drinking	**1 - 2**	**3 – 4**	**5 - 6**	**7 – 8**	**8 or more**	……..
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**	……..
In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?	**No**		**Yes, on one occasion**		**Yes, on more than one occasion**	……
Total Score	**Add up your total score and enter it in the box on the right ⇨**					……

Alcohol Screening Part 2

Questions PART 2	Scoring System 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 standard alcoholic drinks do you have on a typical day when 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 that 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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advised you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
Total Score OF ALL QUESTIONS ABOVE	**Add up your total score and enter it in the box on the right ⇨** **Scoring 8-15 = hazardous drinking, 15-19 = harmful drinking, 20 or more = possible dependence**					