NEW REGISTRATION FORM – AGED 18 AND OVER

Please fill in this form and bring it to the practice with hard copies of current proof of residence (recent utility bill e.g. council, gas, electricity, bank statement or rent agreement) AND **your passport** (other photo ID if passport not available). RETURN FORM & DOCUMENTS BY USING THE ‘SEND US YOUR DOCUMENTS’ SECTION ON OUR WEBSITE (SAVE YOUR COMPLETED FORM AS A FILE + UPLOAD THE FILE ON OUR WEBSITE)

**PART 1: PATIENT DETAILS. Please FILL IN in BLOCK CAPITALS IN BLACK INK.** If writing is not legible this may delay your registration.

**Title:** Mr  Mrs  Miss  Other: \_\_\_\_\_\_ **Gender:** Male  Female  Other: \_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **First name(s)** |  |
| **Previous Surname (Maiden name)** |  | **Date of birth** |  |
| **Home Address** |  | | |
| **Country and place of birth** |  | **NHS Number**  *Contact previous GP* |  |
| **Home phone** |  | **Work phone** |  |
| **UK Mobile phone** |  | **Email address** |  |
| **Next of kin name** |  | **Relationship** |  |
| **Next of kin contact details** |  | | |

**Please list all the names of the people who live in the same house as you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** | **Forename** | **Date of birth** | **Relationship**  ***(i.e. mother, father, husband, brother)*** | **If under 16, do you have parental responsibility?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **If you have children, does anyone else have parental responsibility for them?** | | | Yes  No | | | | |
| **Please list their name and relationship** | | |  | | | | |
| **Do you have or ever had a social worker?** | | | Yes  No | | | | |
| **Please list their name and contact details** | | |  | | | | |
| **What is your nationality?** | | | |  | | | |
| **What is your main spoken language?** | | | |  | | | |
| **Do you need an interpreter or translator?** | | | | Yes | | No | |
| **Ethnicity:**  **White**  *British*  *Irish*  *Other White (please state):* | **Asian or British Asian**  *Indian*  *Pakistani*  *Bangladeshi*  *Other Asian (please state):* | **Mixed Race**  *White& Caribbean*  *White & African*  *White & Asian*  *Other Mixed (please state):* | | | **Black or Black British**  *Caribbean*  *African*  *Other Black (please state):* | | **Chinese or other**  Chinese  *Other (please state):* |

**PART 2: PREVIOUS MEDICAL RECORDS**

Please help us trace your previous medical records by providing **ALL** the details below

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you been registered with us before?** | | Yes  No | |
| **Your previous address in the UK** | |  | |
| **Name and address of your GP at that address** | |  | |
| **If you are from abroad – please write the first UK address where registered with a GP** | |  | |
| **Date you first came to live in UK** |  | **If previously resident in the UK, date of leaving** |  |

**PART 3: COMMUNICATION PREFERENCES AND ONLINE SERVICES**

|  |  |
| --- | --- |
| What is your preferred communication method? | No preference  Home telephone  Work telephone  Mobile telephone  E-mail address  Letter to home |
| Do you consent to the practice using your mobile number to send you texts? | Yes  No |
| Do you have difficulty speaking or using language to communicate or make your needs known? | Yes  No |
| Do you need an assistance of Communication Professional? | Interpreter for Deafblind People  BSL Interpreter  Sign Language Translator  Other: |
| Would you like to join our Patient Participation Group to provide feedback on services? | Yes  No If you tick yes, we will contact you to invite you to our quarterly meetings |

**Online Services**

You can now access your GP record online via Patient Access, this allows you to book appointments, request medications and view your medical record, including results (aged 16+ only).

I would like to register to book appointments:  Yes  No

I would like to register to order prescriptions:  Yes  No

I would like to register to access my record online:  Yes  No

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 | Yes |
| 2. I will be responsible for the security of the information that I see or download | Yes |
| 3. If I choose to share my information with anyone else, this is at my own risk | Yes |
| 4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | Yes |
| 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 | Yes |
| 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. | Yes |

If you have ticked yes to the above, your records will be reviewed and we will provide you with login details to register for access.

**Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy nomination**

Please choose a pharmacy you would like your prescription to be sent electronically to when medication is issued for you. (No need to collect paper prescriptions from the surgery!)

Name of pharmacy: **­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Summary Care Record**

What is a Summary Care Record?

A Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies. This means they can give you better care if you need health care away from your usual doctor's surgery for example:- in an emergency, when your surgery is closed, at outpatient clinics etc.

I would like to register for **enhanced** Summary Care Record  Yes  No

**Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Privacy Notice and Declaration**

The Old Courthouse Surgery will process your personal data in line with Data Protection Act 2018. To access full version of our privacy policy to inform your choices visit our website [www.theoldcourthousesurgery.co.uk](http://www.theoldcourthousesurgery.co.uk) or <https://www.nhs.uk/your-nhs-data-matters/>.

I confirm that the information I have provided is true to the best of my knowledge.

**Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature on behalf of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART 4: PAST MEDICAL HISTORY** Do you have any current medical conditions i.e. diabetes, asthma, stroke or other problems:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Current treatment** | **Date of diagnosis** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you ever had any surgery?**  Yes  No If yes, please complete box below

|  |  |
| --- | --- |
| Name of Operation | Date of Operation |
|  |  |
|  |  |

**Do you have any Allergies?**  Yes  No If yes, please complete box below

|  |  |  |
| --- | --- | --- |
| Medication | Food | Other (please specify) |
|  |  |  |
|  |  |  |

**Medication:**

Are you taking any medication currently  Yes  No If yes, please complete the table below:

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **How often do you take it?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Name of medication** | **Dose** | **How often do you take it?** |
|  |  |  |
|  |  |  |
|  |  |  |

# Family History

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **YES/ NO** | **Who (e.g. parent, sister, grandparent)** | **Age of onset (if known)** |
| **Diabetes** | Yes  No |  |  |
| **Heart disease i.e. angina, heart attack** | Yes  No |  |  |
| **High Blood Pressure** | Yes  No |  |  |
| **Cancer (please specify)** | Yes  No |  |  |
| **Epilepsy** | Yes  No |  |  |
| **Asthma** | Yes  No |  |  |
| **Rheumatoid arthritis** | Yes  No |  |  |
| **Stroke/CVA** | Yes  No |  |  |
| **Other (please specify):** | Yes  No |  |  |

**FOR WOMEN ONLY: CERVICAL SMEAR (If you had a smear abroad or private please supply a copy to avoid being required to have an NHS Smear)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date taken** | **Result** | | **Next test due date** | | | |
|  |  | |  | | | |
| Have you ever had an abnormal smear?  Yes  No | | | Details: | | | |
| Have you had a Hysterectomy?  Yes  No | | Date: | Total | Abdominal | Subtotal | Vaginal |
| Do you use any form of contraception?  Yes  No | | | Please specify: | | | |
| Are you currently pregnant?  Yes  No | | | Expected due date: | | | |
| Have you had female circumcision or been cut down below? | | | Yes  No If yes, when | | | |

# Smoking

|  |  |  |
| --- | --- | --- |
| Current smoker  Date you started: | How many per day: | What do/did you smoke? |
| Never smoked | Ex- smoker  Date you stopped: | cigarettes  roll your own  cigars  e-cigarettes  other |

# Exercise

|  |  |
| --- | --- |
| **Do you exercise** | Yes  No |
| **If yes, how many times per week?** | times per week |

# ALCOHOL CONSUMPTION:

# 

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 |  |

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

**Your score:**

**ONLY if you have scored 5 or more complete the following questions also:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Questions | 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 drinking 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 |  |

Scoring: 0-7 Lower Risk, 8-15 Increasing risk, 16-19 Higher Risk, 20+ Possible Dependance.

**Including your score from the first three questions**

**Your score:**

**PART 5: CARER’S REGISTRATION**

Carers’ Trust Definition:Anyone who cares for, unpaid, a friend or family member who, due to illness, disability, mental health problems or addiction, cannot cope without their support.

**Are you a carer?**  Yes  No **Are you cared for?**  Yes  No

The Surgery may contact you to offer help if you are a carer.

**DETAILS OF THE PERSON YOU CARE FOR**

|  |  |
| --- | --- |
| **Mr**  **Mrs**  **Miss**  **Ms**  **Other** | |
| **Surname:** | **Forename:** |
| **Address:** | |
| **Date of Birth:** | **Email Address:** |
| **Home Phone:** | **Mobile:** |

**HEALTH PROBLEMS OF THE PERSON YOU CARE FOR**

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance Misuse** | | **Alcohol Misuse:** | |
| **Chronic Disease** *e.g. Diabetes, Ischaemic Heart Disease, Stroke (please specify:* | | **Mental Health problem:** | |
| **Learning Disability** | | **Visual Impairment:** | |
| **Physical Disability** | | | **Other** *(please specify)*: | |
| **Do you have a Social Worker or another professional supporting/ involved/helping you** | **Yes**  **No** | | **If yes, Name:**  **Job Title:**  **Contact Details:**  **Which Borough:** | |

**THE OLD COURTHOUSE SURGERY**

**DRS DESAI, FAROOQI, GERRARD, O’DONNELL & GANAPATHI**

**PATIENT AGREEMENT**

Dear Patient,

Thank you for joining the Practice. We aim to provide a high standard of service to our patients. In order for us to maximise the service we are able to offer, we request patients to agree to a number of practical measures.

* Home visits should only be requested for housebound patients or those genuinely unable to come to the surgery. Transport responsibility remains with the patient. Please ring after 8.30am if you are requesting a home visit.
* If you have a genuine medical emergency, please alert the surgery staff by stating this, so that speedy appropriate action may be taken. At times you may be advised to call an ambulance.
* When you have a medical problem needing urgent attention, ring the surgery as early as possible from 8.30am Monday to Friday.
* Cancel any appointments with as much notice as possible.
* Calls outside surgery hours should only be for genuine medical emergencies.
* Urgent appointments – appropriate use of these appointments will help to reduce your waiting time. Sick certificates and repeat prescriptions will not be given during urgent appointments.
* Requests for repeat prescriptions must be submitted 2 working days before they are to be collected – and preferably when you have one week’s supply of your medication remaining. Please note that repeat prescriptions will **NOT** be taken over the telephone, email or fax due to safety issues. Normal repeat prescriptions will be issued for one to two months only.
* Treat the staff with courtesy and respect and they will do likewise.
* Zero tolerance – we have a zero tolerance policy to verbal/physical abuse. Any patients who are abusive to any staff will be asked to register elsewhere.

**A full outline of services offered are contained in the Practice Leaflet**.

Patient given Practice Leaflet  Yes  No

**Signed (staff member): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**