**New Patient Registration Form** Please complete all pages in full using block capitals

**Named accountable GP:**

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| **1. Background Details** | | | | | | |
| **Contact Details** | | | | | | |
| NHS Number | Click or tap here to enter text. | | | *If you have had a previous GP then you will find this on letters/prescriptions or at* [*www.nhs.uk/find-nhs-number*](https://eur01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.nhs.uk%2Ffind-nhs-number&data=04%7C01%7Csupport%40ardens.org.uk%7Cffabf11787fb41dc43be08d99fa70d67%7C2574bae132844b5a8833850acab88d43%7C1%7C0%7C637716362095841893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=MF3g4y6zrx4E0Qifat%2FgKNmjXrzmgNeU5ebPuaEcNAo%3D&reserved=0) | | |
|  | I do not know my NHS number | | | | | |
| Full Name | Click or tap here to enter text. | | | | | |
| Previous Surname (i.e. Maiden Name) | Click or tap here to enter text. | | | Title | Mr  Mrs  Miss  Ms  Dr | |
| Gender | Click or tap here to enter text. | | | Date of Birth | Click or tap here to enter text. | |
| Which of the following best describes how you think of yourself? | Non-binary  Female  Male  Prefer not to say  Unable to answer | | | | | |
| Is your gender the same as the sex you were assigned at birth? | Yes  No | | Prefer not to say  Unable to answer | | | |
| Town & Country of Birth | *(If London, please include Borough)*  Click or tap here to enter text. | | | | | |
| Address | Click or tap here to enter text. | | | Home Telephone | | Click or tap here to enter text. |
| Work Telephone | | Click or tap here to enter text. |
| Previous Address | Click or tap here to enter text. | | | | | |
| Mobile Telephone | I consent to be contacted\* by SMS on this number: Click or tap here to enter text. | | | | | |
| Email | I consent to be contacted\* by email at this address:Click or tap here to enter text. | | | | | |
| Next of Kin | Name: Click or tap here to enter text. Tel: Click or tap here to enter text. Relationship: Click or tap here to enter text. | | | | | |
| Family Registered With Us | | Click or tap here to enter text. | | | | |
| Has the patient been registered in the NHS before?  Yes  No  If no please state date entered UK: Click or tap to enter a date.  If previously resident in UK, date of leaving: Click or tap to enter a date. Date of return: Click or tap to enter a date. | | | | | | |

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

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| **Other Details** | | | | | | | | | | | | |
| Previous GP | Name: Click or tap here to enter text.  Address: Click or tap here to enter text. | | | | | | | | | | | |
| Employment | Employed  Self-employed | | | Student  Unemployed | | | | | House husband  House wife | | | Carer  Retired |
| Occupation | Click or tap here to enter text. | | | | | | If retired, previous occupation: Click or tap here to enter text. | | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | | Black Caribbean  Black African  Black Other | | | | | Bangladeshi  Indian  Pakistani | | | Chinese  Other | |
| Housing | Nursing Home  Homeless | | Residential Home  Sheltered Home | | | | | Housebound  Refugee | | | Asylum Seeker | |
| Overseas Visitor | Yes | | European Health Insurance Card Held (please bring details with you) | | | | | | | | | |
| Armed Forces | Military Veteran | | Family member | | | | |  | | |  | |
| If returning from the Armed Forces | Address before enlisting | | | | Click or tap here to enter text. | | | | | | | |
| Enlistment date | Click or tap to enter a date. | | | | | | | | Leaving date | | Click or tap to enter a date. |
| Service/Personnel number | | | | | Click or tap here to enter text. | | | | | | |
| **Communication Needs** | | | | | | | | | | | | |
| Language | What is your main spoken language? Click or tap here to enter text.  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 | | | | |
| Learning disability | Do you have a Learning Disability?  Yes  No  (If **Yes** please request a Learning Disability Screening Tool form) | | | | | | | | | | | |

*\* If you need any help communicating with us e.g. if you use British Sign Language or you require information in large print or easy read, please let us know.*

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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\*: Click or tap here to enter text. | Tel: Click or tap here to enter text. | Relationship: Click or tap here to enter text. | |

*\* 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** | | | |
| **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:  Click or tap here to enter text.  If you are currently under the care of a Hospital or Consultant outside our area, please tell us here:  Click or tap here to enter text. | | | |

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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:  Diabetes:  Kidney Disease:  Liver Disease: | Heart Disease:  Stroke:  Blood Pressure:  Depression:  Thyroid:  Cancer: |
| Other:  Click or tap here to enter text. | |

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| **Allergies** |
| Please record any allergies or sensitivities below  Click or tap here to enter text. |

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| **Vaccinations** |
| Have you received all routine vaccinations?  Yes  No  Did you receive all your routine vaccinations in the UK?  Yes  No |
| **Current Medication** |
| Please check and include as much information about your current medication below  Please give us your previous repeat medication list if possible and a medication review appointment may be needed  Click or tap here to enter text. |

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| **3. Your Lifestyle** |
| **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 | Click or tap here to enter text. |
| 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+ | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
| A score of **less than 5** indicates *lower risk drinking* | | | | | TOTAL: | Click or tap here to enter text. |

**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 | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in last year |  | Yes, during last year | Click or tap here to enter text. |
| 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 | Click or tap here to enter text. |
|  | | | | | TOTAL: | Click or tap here to enter text. |

[](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 (metres) | Click or tap here to enter text. |
| Weight (kg) | Click or tap here to enter text. |
| Waist Circumference (cm) | Click or tap here to enter text. |

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| **Women Only** | |
| Do you use any contraception? Do you have a coil or implant insitu | Yes  No If needed, please book appointment.  Yes  No Date inserted: Click or tap to enter a date. |
| Are you currently pregnant or think you may be? | Yes  No Expected due date: Click or tap here to enter text. |

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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: Click or tap here to enter text. |

***\*\* If you would like to receive our surgery newsletters please visit*** [***www.queensavenue.co.uk***](http://www.queensavenue.co.uk) ***to sign up.***

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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  To register please visit: [www.blood.co.uk/the-donation-process/recognising-donors](http://www.blood.co.uk/the-donation-process/recognising-donors)  or call **0300 123 23 23** |
| Organ Donation | You will automatically be considered that you agree to become an organ donor when you die unless you are under 18, have opted out or are in an excluded group.  For further information, please see: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) |

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| **Signatures** | |
| Signature | Click or tap here to enter text.  I confirm that the information I have provided is true to the best of my knowledge.  Signed on behalf of patient |
| Name | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |

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| **5. Online Access to Your Health Record** |

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| We offer an online service which will enable you to order prescriptions, book appointments and have access to aspects of your medical record. We require photo ID (passport, driving licence) to enable access. Please ask a receptionist for details. |

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| **6. 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 care for you? (e.g. Emergency Departments)  Yes *(recommended option)*  No, never  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

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

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| **Signature** | |
| Signature | Click or tap here to enter text. |
|  | Signed on behalf of patient |
| Name | Click or tap here to enter text. |
| Date | Click or tap here to enter text. |

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| **7. Data Sharing for Research (not for direct care)** |
| Please note:  You can also tell your GP practice if you do not want your confidential patient information held in your GP medical record to be used for purposes other than your individual care. This is commonly called a Type 1 opt-out. This opt-out request can only be recorded by your GP surgery.  I do not wish identifiable data about me to leave the practice  (For practice use only - **XaZ89**)  Name: Click or tap here to enter text. Signature: Click or tap here to enter text.  Date: Click or tap to enter a date.  You can also object to any information containing data that identifies you from leaving the NHS Digital secure environment. This is the National Data Opt-out and can no longer be set by your GP. This includes information from all places where you receive NHS care, such as hospitals. If you object, confidential information will not leave NHS Digital and will not be used, except in very rare circumstances for example in the event of a public health emergency.  **You can change your choice at any time.**  To find out more or to make your choice visit: **nhs.uk/your-nhs-data-matters** or call **0300 303 5678** |

**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?**

Queens Avenue Surgery 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 about your health records, please see: [www.nhs.uk/NHSEngland/thenhs/records](http://www.nhs.uk/NHSEngland/thenhs/records)

For further information about how the NHS uses your data for research & planning and to opt-out, please see: [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)