**New Patient Registration**

**About you**

Surname: …………………………………… Forename(s): ……………………………………

Date of Birth (dd/mm/yyyy): ………………. Gender: …………………… Title: ……………..

Marital Status: ……………………………… Previous Family Name: .……………………….

**Contact Information**

Telephone: ……………………………………… Mobile: ………………………………………..

Email: …………………………………………… Work: …………………………………………

Please circle below your preferred choice of contact: **Text Phone Email Post**

Do you live in a residential/nursing home? **Yes No**

What is your occupation?........................................................................................................

**Ethnicity**

Having information about patients’ ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients’ needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| British or mixed British |  | Pakistani |  |
| Irish |  | Bangladeshi |  |
| African |  | Chinese |  |
| Caribbean |  | Other (Please state) |  |
| Indian |  |  |  |

**Country of birth**

In which country were you born?...........................................................

**Main language**

Which is your main language?..............................................................

**Religion**

What is your religion? ………………………………………………………

**Service Families and Military Veterans**

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran |  |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. |  | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. |  |

**Carer status**

Do you have a carer? **Yes No**

**If Yes, please give details of their name, relationship and whether they are a patient here too………………………………………………………………………………………………**

Are you yourself a carer? **Yes No**

**If Yes, please give details of their name, relationship and whether they are a patient here …...……………………………………………………………………………………………**

**Next of kin**

Surname: …………………………………… Forename(s): ……………………………………

Gender: …………………………………….. Relationship:…………………………………….

**Emergency contact Information (for next of kin)**

Telephone: …………………………………… Mobile: ………………………………………

**Contacting you**

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Do you consent to the Surgery sending text messages to your mobile? **Yes No**

Do you consent to the Surgery sending messages to you by email? **Yes No**

Do you consent to the Surgery leaving messages on your phone? **Yes No**

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

**Summary Care Record**

Summary Care Record (SCR)

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

**For more information**: Phone 0300 123 3020 or visit [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk/)

I do not wish to have a Summary care Record **I wish to opt out of SCR**

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

**Resuscitation wishes and Power of Attorney**

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes No**

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes No**

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).

Details………………………………………………………………………………………………….

**Smoking status**

Do you smoke? **Yes No**

**If yes,** how many cigarettes do you smoke daily: ……………………………….

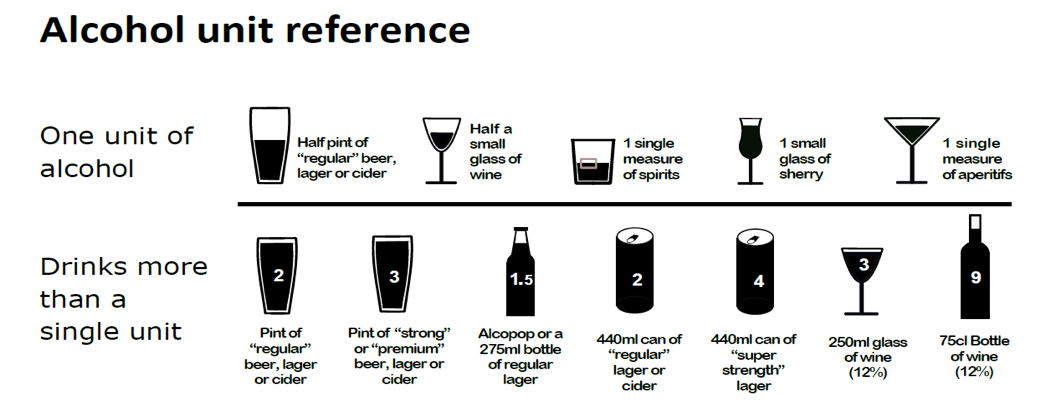
**If no,** have you smoked in the past? **Yes No**

**Smoking is the UK’s single greatest cause of preventable illness**

Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.

*If you would like help and advice on how to give up smoking, please contact* [*https://www.quit4life.nhs.uk/*](https://www.quit4life.nhs.uk/) *or ask at reception.*

**Alcohol intake**



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

*A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |  |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 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 |  |

Please add up your scores from the above tables and write the total below:

**Total**…………………………..

*If you would like help and advice on how to reduce your alcohol intake, please contact* [*https://www.drinkaware.co.uk/*](https://www.drinkaware.co.uk/) *or ask at reception.*

**Height/Weight**

What is your height: …………………………….

What is your weight:…………………………..

*If you would like advice on managing a healthy weight, please contact* [*https://www.nhs.uk/live-well/*](https://www.nhs.uk/live-well/) *or reception who will be able to direct you to the most appropriate service.*

**Disabilities / Accessible Information Standards\_**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs?

**Yes No**

**If yes,** please state your needs below:

**………………………………………………………………………………..**

Do you have significant mobility issues? **Yes No**

**If yes,** are you housebound? **Yes No**

*(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)*

Are you blind/partially sighted? **Yes No**

Do you have significant problems with your hearing? **Yes No**

**Medical History:**

Do you have or have you ever been diagnosed with any of the following: -

Asthma Heart Disease/AF/Angina

Cancer High Blood Pressure

Kidney Disease Epilepsy or “Fits”

Dementia Rheumatoid Arthritis

Depression Mental Health Problems

Diabetes Stroke or TIA

Thyroid Disease COPD/Emphysema

Osteoporosis Peripheral Arterial Disease

Liver Disease Other…………………………………………………

**Family Medical History:**

Does any of your family have or have they ever been diagnosed with any of the following: -

Asthma Heart Disease/AF/Angina

Cancer High Blood Pressure

Kidney Disease Epilepsy or “Fits”

Dementia Rheumatoid Arthritis

Depression Mental Health Problems

Diabetes Stroke or TIA

Thyroid Disease COPD/Emphysema

Osteoporosis Peripheral Arterial Disease

Liver Disease Other…………………………………………………

**Allergies:**

Have you ever had an allergic reaction to medication: **Yes No**

If yes, please give further information.………………………………………………………………

Are you allergic to anything else?.............................................................................................

**Medication:**

Are you currently taking any prescribed medication? **Yes No**

You will need to see a GP here before obtaining a repeat prescription. Please list here:

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**For female patients only**

Are you currently pregnant? **Yes No**

***If yes,*** *please ensure you are under the care of a midwife. If you’re not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present?**............................................**

Do you currently have long acting reversible contraception in place? *(Implant/Coil)*

**Yes No If yes,** when was this fitted? (dd/mm/yy)

**………………………………..……………………**

Have you had a cervical smear test?

**Yes No If yes**, when was this last done? (dd/mm/yy)

**……………………………………………………..**

Have you had a mammogram?

**Yes No If yes,** when was this last done? (dd/mm/yy)

**……………………………………………………..**

**Patient Participation Group**

The Practice is committed to improving the services we provide to our patients.

To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.

By expressing your interest in joining, you will be helping us to plan ways of involving patients that suit you.

It will also mean we can keep you informed of opportunities to give your views   
and keep you up to date with developments within the Practice.

If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

I am interested in becoming involved in the Practice Patient Participation Group

(Please tick the “Yes” Box) **Yes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient**  **Signature:** |  | **Signature on**  **Behalf of the Patient:** |  |

# 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 | 🞏 |
| 1. Limited access to parts of my medical record | 🞏 |
| 1. Order repeat prescriptions online | 🞏 |

**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 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |

|  |  |
| --- | --- |
| Signature | Date |

### For practice use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | | |
| Identity verified by  (initials) | Date | Method  Photo ID and proof of residence 🞏 | | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  Contractual minimum √  Other……………………. ……… | | | Notes / explanation | |

**Accessing GP Records Online**

**Hamstreet Surgery - Patient Information Leaflet**

Practices are increasingly enabling patients to be able to request repeat prescriptions and book appointments online.

Some patients may wish to access more information online and contractually from 1st April 2015 practices are obliged to assist access to medications, allergies and adverse reactions as a minimum and from the 1st April 2016 coded data.

However this requires additional considerations as outlined in this leaflet. You will be asked that you have read and understood this leaflet before consenting and applying to access your records online. The practice will also need to verify your identity.

**Please note:**

* **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**
* **If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**
* **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**
* **The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

|  |
| --- |
| ***Key considerations*** |
| ***Forgotten history***  There may be something you have forgotten about in your record that you might find upsetting. |
| ***Abnormal results or bad news***  If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| ***Choosing to share your information with someone***  It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| ***Coercion***  If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| ***Misunderstood information***  Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| ***Information about someone else***  If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |