# Registration Form

**Please return to Burton Croft Reception**

BURTON CROFT SURGERY
... in the heart of Headingley

| | |
|---|---|
| Title | Mr Mrs Miss Ms Mx |
| Surname | |
| First name (s) | |
| Date of Birth | |
| NHS number | |
| Gender | Male Female Non-binary Other (please specify): |

**Please choose your ethnicity from the list below:**

| | | | |
|---|---|---|---|
| British or mixed British | ☐ | Indian or British Indian | ☐ |
| White Irish | ☐ | Pakistani or British Pakistani | ☐ |
| Other white background | ☐ | Bangladeshi or British Bangladeshi | ☐ |
| White and Black Caribbean | ☐ | Caribbean | ☐ |
| White and Black African | ☐ | African | ☐ |
| Ethnic category not stated | ☐ | Chinese | ☐ |

Other (please state):

| | |
|---|---|
| Are you new to the UK?<br><br>Do you require an interpreter? | Yes ☐ No ☐ Date of entry to the UK:<br><br>If yes, what is your first language: |
| Address<br>(Please include block, flat and room number) | |
| Contact Number | |
| Email address | |

Our method of contact is email, text or telephone. **If you wish to opt out please tick the relevant box.**
We will use your details to remind you of appointments, book reviews and follow-up tests. Information about health campaigns e.g. Flu, NHS Health Checks, along with any significant practice changes. You will also be able to give feedback on the quality of our services.

☐ Not By email ☐ Not By text

| | |
|---|---|
| Place of birth<br>(Town and country) | |
| Previous GP Practice | |
| Previous home address<br>(including postcode) | |

**Staff use only** Photo ID verification details (ID type and number if applicable, please sign and date)

 (Staff use only) Name:_____ EMIS:_____ Date:_____

| | |
|---|---|
| **Nominated Pharmacy** | Please state the pharmacy you would like any medication to be sent to below:<br><br>If you are on repeat medication you **must** book an appointment with a GP or our practice pharmacist before you can order this. |
| **Online Access** | Please state if you would like online access (view test results, order prescriptions, book appointments)<br>Yes ☐ No ☐ |
| **Next of Kin Information** | Is your next of kin a patient at Burton Croft Surgery? Yes ☐ No ☐<br>Next of Kin name: _____ Mr/Mrs/Miss/Mx<br>Relationship to you: _____<br>Contact number (UK only): _____<br>Is this person your emergency contact? Yes ☐ No ☐<br>Can this person discuss your medical record with us? Yes ☐ No ☐<br>Is this person a registered carer for you? Yes ☐ No ☐ |
| **Health Information** | Height (in CM) Weight (in KG): |
| **Smoking Status** | Do you smoke tobacco? Yes ☐ No ☐ E-cigarettes/Vape ☐<br>If yes, how many per day? _____<br>Have you ever smoked? Yes ☐ No ☐<br>If you are an ex-smoker, when did you stop? _____<br>How many per day did you smoke? _____ |
| **Are you a military veteran?** | Yes ☐ No ☐<br>We are a veteran friendly practice, please ask for more information at reception if you need support. |
| **Do you have any allergies?**<br>If yes please state: | Yes ☐ No ☐ |
| **Do you have any medical conditions or disabilities?**<br>If yes please state: | Yes ☐ No ☐ |
| **Have any of your blood relatives have suffered from the following:**<br>-Hypertension -Stroke<br>-Heart attack -Diabetes<br>-Breast or Ovarian Cancer | Yes ☐ No ☐<br>If yes, please state which member of your family, what did they/do they suffer from and what age were they diagnosed. |
| **Do you help to look after someone who is ill, frail or disabled?** | Yes ☐ No ☐<br>If Yes, who do you look after (e.g. partner, child, relative or friend?)<br>_____<br>Do they live with you? Yes ☐ No ☐<br>Are they registered at this practice? Yes ☐ No ☐<br>Carers Leeds offers a confidential support and information service to carers.<br>If you would like further information, please ask one of our receptionists for their leaflet. |

# Alcohol screening:

**1 unit is typically:**

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

**UNIT GUIDE**

**The following drinks have more than one unit:**

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)


The following questions are validated as screening tools for alcohol use

## AUDIT- C Questions

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

**<u>Scores of 5+</u>** requires the following 7 questions to be completed:

## AUDIT Questions

(after completing 3 AUDIT-C questions above)

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

 (Staff use only) Name:_____ EMIS:_____ Date:_____