|  |  |
| --- | --- |
| New Patient Registration Form **(UNDER 16)** |  |
| **The Ruddington Medical Centre**  **Thank you for taking the time to complete this medical questionnaire, the information you provide will help improve our service to you.** | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Patient Details** | | | | | | | | | |
| **NHS No.** |  | | | **Town & Country of Birth** | |  | | | |
| **First** **Name** |  | | | **Surname** | |  | | | |
| **Known as** | *(if different from first name)* | | | **Date of Birth:** | |  | | | |
| **Gender** | Male  Female  Indeterminate  Unspecified / Unknown | | | | | | | | |
|  | | | | | | | | | |
| **Ethnicity** | **White** | **Black** | | **Asian / Asian British** | | | **Chinese & Mixed Background** | | |
| British | Caribbean | | Indian | | | Chinese | | |
| Irish | African | | Pakistani | | | White & Black Caribbean | | |
| Other: | | | Bangladeshi | | | White & Black African | | |
|  | | | White & Asian | | |
|  | | | | | | | | | |
| **Language** |  | | | | **Interpreter Needed** | | | | Yes  No |
|  | | | | | | | | | |
| **Religion** | C of E | | Buddhist | | Sikh | | | No religion | |
| Catholic | | Hindu | | Jewish | | | Other: | |
| Other Christian | | Muslim | | Jehovah’s Witness | | |  | |
|  | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Contact Details & Address** | | | | | | **Preferred** |
| **Home Phone** |  | | | | |  |
| **Mobile Phone** |  | | | | |  |
| **E-mail** |  | | | | | |
| **Consent** | If you give us a mobile and/or email we will assume you are happy for us to contact you using them. If you are **NOT** happy to be contacted this way please tick the box : | | | | | |
| **Current Address** |  | | | | **Postcode** | |
|  | |
| **Address Type** | Home | Temporary | Correspondence Only | Other: | | |
| **If you still attend Nursery/School, which Nursery/School do you attend?** | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Family, Relationship & Emergency Contact Details** | | | | | |
| **Next of Kin**  **Name:**  **Relationship:**  **Contact Details:** |  | | **Next of Kin**  **Name:**  **Relationship:**  **Contact Details:** | |  |
| **Names & Ages of Children**  **(if applicable)** | |  | | | |
| **Other individuals in your household (if applicable)** | |  | | | |
| **Emergency Contact/s**  *(name, number & relationship)* | |  | | | |
| **Are you happy for your medical information to be shared with your Next of Kin??** *(please circle as appropriate)* | | | | **YES / NO** | |

|  |  |
| --- | --- |
| 1. **Association(s) with Medical Practice** | |
| To the best of your knowledge, are any of your relatives or friends currently employed by the Medical Practice? | |
| Yes | No |
| *Staff note: If ‘Yes’ to question above, advise patient of staff records access policy* | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Accessible Information Needs** | | | | |
| **Condition / Issue** | Registered  Blind | Registered  Deaf | Other: | |
| **When we speak to you** | British Sign Language | Lip reader | Hearing aid | Other: |
| **When we write to you** | Braille | Large print | Easy read | Other: |
| **Preferred Contact Method** | Telephone | Text message | Post | Other: Email |
| **Other Communication Needs** |  | | | |
|  |  | | | |
| **Nominated pharmacy for electronic prescriptions(EPS)** | **We use the NHS Electronic Prescription Service (EPS). Please tell us who you would like as your nominated dispenser/pharmacy, then we will send your prescription electronically to them.**  ***Otherwise, when you request a repeat prescription we will send it to Evans Pharmacy on Charles Street in Ruddington to be dispensed. The prescription will be ready to collect in 48 hours.***  **My nominated dispenser/pharmacy, is (Name and Location):** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Family History** | | | |
| Please tell us about any important family history of close relatives with medical problems and confirm which relative e.g. Mother, Father , Grandparent or Sibling (brother or sister) | | | |
| **Condition** (tick all that apply) | **Which relative?** | **Condition** (tick all that apply) | **Which relative?** |
| Arthritis |  | Heart Failure |  |
| Asthma |  | Hypertension |  |
| Autoimmune Disease |  | Heart Disease |  |
| COPD |  | Kidney Disease |  |
| Cardiovascular Problem |  | Liver Disease |  |
| Dementia |  | Peptic Ulcer Disease |  |
| Depression |  | Thyroid Disorder |  |
| Diabetes |  | Stroke |  |
| Epilepsy |  | Cancer |  |
| **Other relevant family history not listed above:** | |  | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Carer Details** | | | | | | | | |
| Do ***you*** have a carer who *you* are **dependent on** for some or all of the time? | | | | | | | | Yes  (has a carer)  No |
| **Your Condition** | | Physical Disability  Mental Health Problem  Terminal Illness  Learning Disability  Chronic Disease  Sensory Impairment  Dementia  Alcohol Misuse  Other:  Substance Misuse  Elderly | | | | | | |
| **Name of Person** |  | | | **Patient at this practice?** | | | | Yes  No |
| **Relationship to you** | Child (young carer) | | Relative | | | Other: | | |
| **Type of** Carer | Informal | | Paid | | | Parent | Other: | |
| Carer **Address**  *(if different to yours)* |  | | | | | | | |
| Carer **Home Phone Number** |  | | | | Carer **Mobile Phone Number** | | |  |
| Carer **Email Address** |  | | | | **Does the carer hold a care plan for you?** | | | Yes  No |
| **I am happy for you to share my health care record / information with my carer:** | | | | | | | | Yes  No |
| **Would you like information on support services for carers?** | | | | | | | | Yes  No |

|  |  |
| --- | --- |
| 1. **Record Sharing For Direct Care** | |
| **What is direct care?**  Direct care means that a health worker caring for you wishes to access information held in your GP record that will help them to treat you better. **This data is NEVER used for research purposes or marketing.** | |
| **Local Record Sharing for Direct Care** | |
| Your GP record can be made available to other health care services such as out of hours, emergency services, other GP practices, community services and hospital consultants.  **You will be asked every time by anyone accessing your GP record from outside the practice.** | |
| I am happy to share my GP record to local care services |  |
| I do NOT wish to share my GP record to local care services \*  ***(By ticking this box this limits the information we can share with other local health care providers which may compromise the care you may be given)*** |  |

|  |  |  |
| --- | --- | --- |
| **SCR Sharing for Direct Care** ( SCR information line: 0300 123 3020 [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) ) | | |
| The Summary Care Record (SCR) is a national scheme used to support your direct care. The information will be very limited, and includes medication, allergies and adverse drug reactions.  **You will be asked every time by anyone accessing your SCR from outside the practice (unless you cannot give permission).** | | |
| I am happy to have a summary care record created |  |  |
| I do **NOT** wish to have a summary care record created \*  ***By ticking this box this limits the information we can share with other health care providers such as hospitals, out of hours etc which may compromise the care you may be given)*** | |  |
| I wish to have access to the following online services (please tick all that apply): 1.Booking appointments\*  2.Requesting prescriptions\*  3.Viewing summary care data\* (allergies and medications)  4.Complete questionnaires\*  5.View coded medical record\*\* –patients aged 16 and over ONLY | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Signatures** | | | |
| I confirm that the information I have provided above is true to the best of my knowledge. | | | |
| **Signature** |  | | |
| Signed by patient | Signed on behalf of patient | |
| **Name** |  | **Date** |  |

|  |  |  |
| --- | --- | --- |
| 1. **Checklist** | | |
| Thank you for completing this form. Please check you have completed all sections where possible. | | |
| Please ensure that you bring the following with you to the surgery to complete your registration: | | |
| **1.** | **Completed & Signed GMS1** |  |
| **2.** | **Completed & Signed New Patient Registration Questionnaire** (this form!) |  |
| **3.** | If possible, your **Immunisation Records** – usually the Personal Child Health Record (“Red Book”) |  |
| **4.** | If relevant, your **Repeat Medication Request Slip** from your previous GP |  |
| **5.** | If relevant, your **European Health Insurance Card** |  |

**Thank you for completing this form – please return it to reception**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **For General Practice Use Only** | | | | | | |
| Appointment | Required | | Not Required | |  |  |
| Verified | Mobile Number | | Work Number | | Home Number | Email |
| Photo ID | Passport | | Driving licence | | Identity card | Other |
| Proof of Address | Utility Bill | | Council Tax | | Bank Statement | Other |
| Name of person who authorised and added to system |  | | | | | |
| Online Services Details | | | | | | |
| Date account created: | | | | Date passphrase sent : | | |
| Level of record access enabled | | | | | | |
| Allow appointment booking | | | | Allow completing questionnaires | | |
| Allow viewing summary record | | | | Allow medication requesting | | |
| Record Access | | | | | | |
| Full record | | Full content | | Prospective  content from date dd / mm /yyyy | | |
| Detailed coded record | | Full content | | Prospective  content from date dd / mm /yyyy | | |
| Notes / explanation | | | |  | | |