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

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| **1. Background Details** |

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| **Contact Details** | | | | | | | |
| **NHS Number** | Click here to enter text | | **Gender** | | Click here to enter text | | |
| **Forename** | Click here to enter text | | | | | | |
| **Surname** | Click here to enter text | | | | | | |
| **Address**\* | Click here to enter text | | | **Date of birth** | | | Click here to enter a date |
| **Contact number\*** | | | Click here to enter text |
| **Email address\*** | | | Click here to enter text |
| **Contact\*** | If you do not consent to being contacted by SMS or email, please specify: | | | | | SMS  Email | |
| **Consent** | Do you consent for us to discuss your health needs with anyone? | | | | | Yes  No | |
| If Yes, please provide their details below: | | | | | | |
| Name: Click here to enter text | Tel: Click here to enter text | | | | Relationship: Click here to enter text | |
| **NHS Registration** | Has the patient been registered in the NHS before? Yes  No | | | | | | |
| If No, please state date entered UK: Click here 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** | | | | | | | | | | |
| **Country of birth** | Click here to enter text. | | | | | | | | | |
| **Ethnicity** | White (UK)  White (Irish)  White (Other) | | Black Caribbean  Black African  Black Other | | | | Bangladeshi  Indian  Pakistani | | | Chinese  Other |
| **Religion** | C of E  Catholic  Other Christian | | Buddhist  Hindu  Muslim | | | Sikh  Jewish  Jehovah’s Witness | | | No religion  Other | |
| **Housing**  (other than Owned / Rented Property) | Nursing Home  Residential Home | | | Sheltered home  Homeless | | | | Housebound | | |
| **Overseas Visitor** | Yes | European Health Insurance Card Held (please bring this with you) | | | | | | | | |
| **Armed Forces** | Military Veteran | | | | Family member / Dependant in the forces | | | | | |
| Do you feel you would benefit from additional support  from the practice as a result of time in the forces? | | | | | | | Yes  No | | |
| If so, please briefly describe what additional support you may need. This could relate to your mental health, a disability or impairment, an injury sustained during combat etc.  Click here to enter text | | | | | | | | | |

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| **Identifying Patient Needs** | | | | | |
| **Language** | What is your main spoken language? Click here to enter text.  Do you need an interpreter?  Yes  No | | | | |
| **Communication** | Do you have any communication needs?  Yes  No  If Yes**,** please specify: | | | | |
| Hearing aid  Lip reading | Large print  Braille | | British Sign Language  Makaton Sign Language | |
| **Disability** | Do you have a learning disability or a physical disability?  Yes  No  If Yes, please provide any information below:  Click here to enter text | | | | |
| **Accessibility** | Do you have any accessibility needs?  Yes  No  If Yes**,** please specify: | | | | |
| Wheelchair  Mobility aid i.e. a rollator | | Crutches  Guide dog / Service animal | | Other: Click here to enter text. |

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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  No | | | | |
| If Yes, please provide their details below: | | | | |
| Name: Click here to enter text | Tel: Click here to enter text | | Relationship: Click here to enter text | |
| Do you consent for us to share information about your health with your carer? | | | | Yes  No |

*\* Please 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** |

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| **Medical History**  *We will take your medical history from your electronic record but if there is something you think is important for us to know before we receive your registration, please summarise it below* |
| Click here to enter text |

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

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| **Current Medication**  *Please let us know any repeat medications you are currently on and if you need to order any soon* |
| Click here to enter text |

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| **3. Your Lifestyle** |

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| **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 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 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 here to enter text |
|  | | | | **Total:** | Click here to enter text | |

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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 or  do you smoke a day? | One or less | 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 here to enter text |
| Weight (kg) | Click here to enter text |
| Waist Circumference (cm) | Click here to enter text |

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| **Women Only** | |
| Do you use any contraception? | Yes  No |
| If needed, please ensure you book an appointment once registered |
| Are you currently pregnant or think you may be? | Yes  No |
| If Yes, please provide an expected due date (if known): Click here to enter a date |

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| **4. Further Details** |

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| **Prescriptions**  *If you live more than 1.6km from the nearest chemist, we are able to dispense your prescriptions to you. If you do not, we will need to know which local pharmacy you would like us to send your electronic prescription* | |
| Please nominate a local pharmacy to receive your electronic prescription: | Nominated pharmacy: Click here to enter text |

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| **Patient Involvement** | |
| Would you like to be involved in our Virtual Patient Group? | Yes  No |
| Would you like to receive more information about the Spinney Surgery Patient’s Association? | Yes  No |
| Would you like to be offered information about research studies at the practice? | Yes  No |

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

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| **5. 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:

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| * 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 (LPA), they may consent on your behalf. If you do not have a LPA, 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?**

The Spinney 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

**FURTHER INFORMATION**

For additional information about your health records:

[www.nhs.uk/NHSEngland/thenhs/records](http://www.nhs.uk/NHSEngland/thenhs/records)

To see how the NHS uses your data for research & planning and to opt-out:

[www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)

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| **5. Sharing Your Health Record (continued)** |

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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? | Yes *(recommended)*  No, never |
| Do you consent to your GP Practice viewing your health record from other organisations that care for you? | Yes *(recommended)*  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)*  No |

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| **Signature** | |
| **Signature** | Click here to enter text |
|  |
| **Name** | Click here to enter text |
| **Date** | Click here to enter a date |