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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT REGISTRATION FORM** | | | | | | | | |
| Today’s Date: | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | |
| Surname: | | Forenames: | | | | | | |
| Date of Birth: | | Occupation: | | | | | | |
| Ethnic Origin: | | Main Language: | | | | | | |
| Tel No. Home: | | Tel. No. Mobile: | | | | | | |
| E-mail: | | | | | | | | |
| It’s important you provide your e-mail to get online access to your medical records. We will also keep you updated on our services. | | | | | | | | |
| **IN CASE OF EMERGENCY/NEXT OF KIN** | | | | | | | | |
| Title: | | | | Gender: | | | | |
| Full Name: | | | | Relationship: | | | | |
| Address: | | | | Contact number: | | | | |
| **HISTORY** | | | | | | | | |
| **Alcohol** | | | | | | | | |
|  | | | | | | | | |
| **Questions** | **Scoring System** | | | | | | | **Your Score** |
|  | **0** | | **1** | | **2** | **3** | **4** |  |
| **AUDIT-C QUESTIONS** |  | |  | |  |  |  |  |
| 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 | 1-4 | | 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 |  |
| **ONLY ANSWER the following question if your score is 5 or more** | | | | | | | | |
| How often do you have 8 (men) / 6 (women) or m ore drinks in one occasion? | Never | | Less than Monthly | | Monthly | Weekly | Daily or almost daily |  |
| **ONLY ANSWER the following questions if your previous answer is monthly or less** | | | | | | | | |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | | Less than monthly | | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | | Less than monthly | | Monthly | Weekly | Daily or almost daily |  |
| Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down? | Never | | Less than monthly | | Monthly | Weekly | Daily or almost daily |  |
| *A total* ***score of 3+*** *indicates hazardous or harmful drinking* |  | |  | |  |  | Total: |  |

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| Have you had any serious operations or injuries? | | | |
| Do you have any current health problems? | | | |
| **PRESENT MEDICATION – Please bring repeat medication slips from previous doctor** | | | |
| **Name of Medication** | **Dose** | **When started** | |
|  |  |  | |
|  |  |  | |
|  |  |  | |
| **Would you like your repeat prescription to be sent directly to a chemist? Yes** ❑ No❑  If the answer is yes, please provide chemist details you would like your prescription to be sent to: | | | |
| **CONTACTING YOU / GDPR CONSENT** | | | |
| **Do you need any communication support needs relating to disability, impairment or sensory loss?** Yes ❑ No❑  **If yes please specify:** ……………………………….……………………………….……………………………….……………………………….  Please let us know how we can best meet your needs when trying to contact you i.e send txt messages only, large print letters or use a specific communication service: ……………………………….……………………………….……………………………….……………………………….……………………………….  ……………………………….……………………………….……………………………….……………………………….………………………………..  **In accordance with the GDPR, the Practice needs consent from you (the patient) on how we can contact.**  **If we do not have consent, we will be unable contact you.** This consent is to remain in force until further notice of cancellation by you.  **Please circle your permission for the following methods of contact that we use in the practice:**  **SMS (text messages) YES / NO**  **Telephone YES / NO**  **Voicemail YES / NO**  **Email YES / NO**  **Post YES / NO** | | | |
| **SUMMARY CARE RECORD – your emergency care summary** | | | |
| Today, records are kept in all the places where you receive care.  These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.  We are introducing Summary Care Records to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when your GP practice is closed. We are telling you about this before a Summary Care Record is made for you, so that you have time to think about your choices.  **You can choose to have a Summary Care Record:**  You do not need to do anything. This will happen automatically. Healthcare staff will ask your permission every time they look at your Summary Care Record.  **You can choose not to have a Summary Care Record:**  If you don’t want a Summary Care Record, you need to let your GP practice know by filling in and returning an opt-out form.   1. ❑ **I do** want my records to be sent to other services 2. ❑ **I do NOT** want my records to be sent to other services | | | |
| **CareMyWay RECORD** | | | |
| What is CareMyWay?  CareMyWay is a new Integrated Digital Care Record which means that for the first time, all of your health and social care data will be stored in one place. This will mean a faster, better service for you.  Health and social care professionals can make better decisions about your care if they have up-to-date, more complete information available to them. The CareMyWay Integrated Digital Care Record will improve information sharing between the organisations providing health and social care services. This will mean that more time can be spent on care and better decisions can be made about your care  You can choose if you want a CareMyWay Integrated Digital Care Record. Your CareMyWay Integrated Digital care can only be seen by health and social care professioanls involved In your care, and only after you have given permission for them to look at it.   1. ❑  **Yes** I would like a CareMyWay Integrated Digital care Record 2. ❑ **No**  I do not want a CareMyWay Integrated Digital care Record | | | |
| **ONLINE ACCESS TO GP SERVICES** | | | |
| If you wish to, you can now request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.  **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.**  **I wish to have access to:** | | | |
| Requesting Repeat Prescriptions | | | 🞏 |
| Accessing my medical records | | | 🞏 |
| **To access your medical records make sure you understand the following:** | | |  |
| I will be responsible for the security of the information I see or download | | | 🞏 |
| If I choose to share my information with anyone else, this is at my own risk | | | 🞏 |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | | 🞏 |
| If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | | | 🞏 |
| **COORDINATE MY CARE** | | | |
| Coordinate My Care puts you at the heart of planning your urgent medical care. It makes sure that your wishes are taken into account by everyone who will be looking after you.  You create a care plan together with your doctor. It includes important information about your illness, how and where you’d like to be cared for and people to contact in an emergency.  If you would like a “Coordinate My Care” appointment please tick this box 🞏 | | | |
| **CARER’S REGISTRATION** | | | |
| Do you look after anyone? ❑ Yes ❑ No  Who do you care for? Name : Date of Birth:  ❑ Please pass my details to the Carer’s Service.  ❑ Please refer me to Adult Care Services for a Carer’s Needs Assessment.  Do you have any information or communication needs? (I.e. large print, braille, sign language, deafblind intervener, contact by text)? ❑ Yes ❑ No Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **PATIENT PARTICIPATION GROUP** | | | |
| Would you like to join our Patient Participation Group? ❑ Yes ❑ No  The Beaumont Practice Patient Participation Group (PPG) is run by volunteer patients and our practice manager to help strengthen the relationship between the practice and you, our patients. You can give your feedback and suggestion s in improve patient experience. | | | |

**Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | Name of verifier | Date |
| Name of person who authorised  (if applicable) |  | | Date |