Station Road Surgery

74 Station Road, West Wickham, Kent BR4 9LE

ADULT NEW PATIENT REGISTRATION FORM

**Please complete in BLOCK CAPITALS**

PERSONAL DETAILS

Mr/ Mrs/ Miss/Ms/ Other: NHS Number:

Surname:

Forename(s):

Previous surname(s) ……………………………………..

Date of Birth:

Male  Female  Town and Country of Birth:

Home Address:

……………………………………………………………….

Postcode:

Email address (IN BLOCK CAPITALS):

Mobile: …………………………………….… Home tel:

Previous Address:

……………………………………………………………….

Postcode:

ETHNICITY

Which ethnic group are you?

British/mixed British  Any other Black background  Indian

Northern Irish/British Irish  White and Black Caribbean  Pakistani

Gypsy or Irish Traveller  White and Black African  Bangladeshi

Other White background  White and Asian  Chinese

Caribbean  Any other mixed background  Other Asian background

African  Prefer not to say

VETERANS

Are you a veteran?  Yes  No

Are you a family member of a veteran?  Yes  No

If yes please provide details:

NHS ORGAN DONOR REGISTRATION

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

Any of my organs and tissue or

Kidneys  Heart  Liver  Corneas  Lungs  Pancreas

Signature confirming my consent to join the NHS Organ Donor

Signature: Date:

PREVIOUS GP

Previous GP name: Previous GP practice address:

IF MOVED FROM ABROAD

Date of entry into UK:

NEXT OF KIN

Name: Contact tel no:

Relationship to you:

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes  No

If “Yes”, would you like them to deal with your health affairs here? Yes  No

Name: Contact No:

Do you care for anyone else? Yes  No

NOMINATE YOUR PHARMACY

All prescriptions are sent electronically to your nominated pharmacy.

Name of nominated pharmacy:

Pharmacy address:

DATA SHARING

**Summary Care Record:** We will automatically create a Summary Care Record for you on registration. This SCR will only be used in an emergency to access information about their medication and allergies. If you do NOT wish your child to have an SCR created, please complete an Opt Out Form, available from reception.

**Care Data:** If you do NOT wish medical information being extracted by NHS England/Health & Social Care Information Centre and/or being shared by them with other health and social care settings, please write to the surgery expressing your request for this not to happen, or ask for a form from reception.

Your GP Practice is supporting Summary Care Records and as a new patient of this practice you have a choice:

**Yes, I would like a Summary Care Record** (you do not need to do anything and a Summary Care Record will be created for you in due course once you have selected which record you would like below:

Implied Consent for medication, allergies, adverse reactions only and additional information

Implied Consent for medication, allergies and adverse reactions only

**No, I do not want a Summary Care Record** (please ask for a form at reception, complete and return to reception)

Signed: Date:

HEALTH CHECK

Height in cm: Weight in kg:

**SMOKING**

Do you smoke? Yes  No

If Yes, how many:

Cigarettes per day …….. Cigars per day ..….. Ounces of tobacco per day ……..

**EX-SMOKERS**

When did you stop smoking? ………………… How many did you smoke per day? ………

**ALLERGIES**

Are you allergic to any substances or foods? Yes  No

If yes, please give details:

**DISABILITY**

Do you consider yourself to have a disability? Yes  No

If ticked “**Yes**” to the above, please indicate your disability:

Learning disability/difficulty  Sensory impairment  Other (please state):

Mental health condition  Physical impairment

Long standing illness  Not declared

ALCOHOL CONSUMPTION

This is one unit

of alcohol…

…and each of these is more than one unit

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT C** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 1. 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 |  |
| 1. 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+ |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| ***Scoring:***  *0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence* | | | | | **TOTAL SCORE:** |  |