Leamore GP
Harden Health Centre
Harden Road
Walsall
WS3 1ET
Tel No: 01922 475015

Adult Registration Form (18 yrs +)

Please complete form in full – Incomplete forms, will not be processed. If questions on this form are not applicable to you then please state **N/A.**

Requirements for Registration

Once you have completed the registration pack please use the tick box below as a guide to confirm evidence of proof of your identity and address to help process your registration successfully**.** Please attach two forms of ID from each list below.

Select ID attached with this form X;

GMS1	**Please complete and keep attached with registration pack.**				
NHS Identification	**Tick**	**Evidence of identity**	**Tick**	**Evidence of address**	**Tick**
GMS1 Form (Please keep attached with registration pack)	☐	Passport	☐	Utility Bill (current)/Bank Statement	☐
		Driving Licence	☐	Council Tax	☐
		Birth Certificate	☐	State Benefit	☐
				Tenancy agreement	☐

***Other Family Members**

Due to safeguarding policy, our practice requirement is that we register all members living in the same household.
Please list down below everyone in the household and, or if registered at another practice.

	Name:	**Name of Their Practice:**
1)	……	……
2)	……	……
3)	……	……
4)	……	……
5)	……	……
6)	……	……

Repeat Medication

Are you on any repeat medication? YES ☐ NO ☐ (X to select)

If Yes, please ensure you have up to **4 weeks**, worth of prescription upon registration.
Please also provide a copy of all your repeat medication that you have been prescribed.
Proof can be either the B side of prescription or letter or medical summary from your GP/consultant stating medication name, dosage, quantity, date of issue.

Failure to do this will result delay in your registration

Personal Details

Mr, Mrs, Miss, Ms, Master: _____ Forenames: _____ Surname: _____

Middle Name: _____ Any other name; _____

Address: _____

Postcode: _____ Date of Birth; _____ Marital Status; _____

Home Tel: _____ Mobile: _____ Work: _____

Email; _____ Place of Birth; _____

Gender; F ☐ M ☐ Have you had a gender change; Yes ☐ No ☐ Sexuality; _____

Are you happy to be contacted, via SMS or Mobile Yes ☐ No ☐

Your preferred method of contact Home ☐ Mobile ☐ Work ☐

Your Next of Kin

Name of next Kin; _____ Relationship: _____

Address: _____

Postcode: _____

Tel: _____Mobile: _____ Work: _____

Previous GP Details;

Are you currently registered with any other practice? Yes ☐ No ☐

If yes, who? _____

Have you tried to register at another practice locally? _____

Outcome; _____

Why are you moving? _____

If you were previously registered with us why did you leave? _____

Why are you returning? _____

Name of your previous GP; _____

Address of previous GP; _____

Postcode: _____

ETHNIC GROUP DATA COLLECTION - STRICTLY CONFIDENTIAL

The Health Service needs to know the ethnic group of patients for the purpose of planning. This is to make sure that all sectors of the community have equal access to the services provided. Ethnic group describes how you see yourself, and is a mixture of culture, religion, skin colour, language, the origins of yourself or your family. It is not the same as nationality. The information given will be treated in the strictest confidence. The information is used only by National Health Service Staff and will not be passed on to other agencies or used for any other purposes.

Please select below:

☐ White – British	☐ White – Irish	☐ Any other White	☐ Mixed - White and black Caribbean	☐ Mixed – White and black African
☐ Mixed White and Asian	☐ Any other mixed group	☐ Pakistani	☐ Bangladeshi	☐ Any other Asian background
☐ Indian	☐ Black Caribbean	☐ Black African	☐ Any Other Black background	☐ Chinese
Any other Ethnic group! _____ Do Not Want to Give Ethnic Group: _____				
Are you an Oversea's visitor? Yes ☐ No ☐ (If yes) Date of Entry: **If yes please provide copy of passport.**				

Special Communication Needs

Language	**Do you speak English?. Yes ☐ No ☐ (if no please specify)** **What is your main spoken language? Please specify** _____ **Do you need an Interpreter? Yes ☐ No ☐**
Communication	Do you have any communication needs? Yes ☐ No ☐ ☐ Braille ☐ British Sign Language ☐ Guide Dog ☐ Lip reading ☐ Makaton Sign Language ☐ Hearing Aid ☐ Large Print
Mobility	Wheelchair User: Yes ☐ No ☐

Carer Details

Are you are carer? Yes ☐ No ☐ (If yes) Paid ☐ Unpaid ☐

Do you have a carer; Yes ☐ No ☐ (If yes) Name; _____

Relationship to you; _____ Tel; _____

Please gain consent before having these details stored on your medical record.

Additional Information

Religion	☐ No religion ☐ Buddhist ☐ Catholic ☐ Christian ☐ C of E ☐ Hindu ☐ Jehovah's witness ☐ Jewish ☐ Muslim ☐ Sikh ☐ Other specify!
Employment	☐ Student ☐ International Student ☐ Carer ☐ Employed ☐ Self-Employed ☐ Housewife ☐ Housebound ☐ Retired ☐ Unemployed
Armed Forces	☐ Military Veteran ☐ Family Member
Housing	☐ Own house ☐ Rented ☐ Housebound ☐ Nursing home ☐ Residential home ☐ Shared home ☐ Homeless ☐ Refugee ☐ Asylum seeker` ☐ Sheltered home

Medical History

Please provide any significant family history of close relatives with medical problems and confirm which relative, e.g Mother, Father, Brother, Sister, Grandparent

Do you suffer with any of the following conditions:

Please provide any significant family history of close relatives with medical problems and confirm which relative e.g Mother, Father, Brother, Sister, Grandparent

☐ Asthma _____ ☐ COPD _____ ☐ Epilepsy ____ ☐ Liver Disease ___

☐ Blood Pressure ____ ☐ Depression __ ☐ Heart Disease ___ ☐ Kidney Disease___

☐ Cancer _____ ☐ Diabetes ____ ☐ Heart Failure _____ ☐ Stroke _____

Other: _____

If you are prescribed or taking any medications, please list here.

Please supply us with a copy of your repeat medication list. Please note a medication review appointment may be required for us to issue these before we add these to your repeat medications at our surgery. Please provide a summary from your previous GP, consultant letter or right side of prescription slip.

Do you Have Any Allergies

Do you have any allergies that you know of or ever had an allergic reaction?

Food:_____

_____

Medication:_____

_____

Other: _____

_____

Lifestyle

Height _____ Weight _____

Are you a smoker? Yes ☐ No ☐ Ex-Smoker ☐

If yes, Do you use e-Cigarette Yes ☐ No ☐ Ex-user ☐

Cigarettes ☐ How many? _____

Cigars ☐ How many? _____

Pipe ☐ oz/grams of tobacco? _____

Never smoked ☐

Women Only

Getting vaccinated while you're pregnant is highly effective in protecting your baby from developing whooping cough in the first few weeks of their life.

The immunity you get from the vaccine will pass to your baby through the placenta and provide passive protection for them until they are old enough to be routinely vaccinated against whooping cough at 8 weeks old.

Are you pregnant or, may think, you are? YES ☐ NO ☐

(If yes) Date of 1st day of last period: _____

Expected due date: _____

If Yes, have you had your whooping cough and flu vaccinations? Yes ☐ No ☐ Unsure ☐

Students in Full/Part Time Education: (under 25 yrs old)

I have had two doses of the MMR vaccination Yes ☐ No ☐ Unsure ☐

I have had a Meningitis C vaccination Yes ☐ No ☐ Unsure ☐

Electronic Prescriptions - EPS

We use Electronic Prescribing Service please nominate a pharmacy of your choice or select from the list below.

118 Pharmacy ☐

Broadstone; ☐ Coalpool; ☐ Harden; ☐ Pritchards; ☐

Other: _____

Patient Participation Group

The Patient Participation Group (PPG) is a group of volunteer patients, the practice manager and GP from the practice who meet on a regular basis to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice.

There is no set way in which this group works the aim and work depends entirely on the local needs they are and have the aim of making sure that their practice puts the patient, and improving health, at the heart of everything it does. The PPG group is an important and a valuable, asset who help us change our services when needed with the valuable feedback from the group.

Would you like to be part of our PPG Group? Yes ☐ No ☐

If yes, your details will be forwarded to the chair of the group who will then make, contact with you.

Declaration

Signature:	**Date**:

Please Note: Practice Policy for the following Controlled Drugs

Medication

Please supply us with a copy of any medication prescribed. A brief medical summary from your GP practice or a letter from the consultant. You will need to be booked for a health check and medication review before any medication can be issued.

If you are taking any benzodiazepine and "Z" drugs such as diazepam, Temazepam or Zopiclone the doctor will monitor your usage and will gradually reduce your medication until you have been weaned off, following the criteria below:

Identifying patients appropriate for withdrawal. All patients taking benzodiazepines and "Z" drugs will fall into several different categories and will require different management strategies:

- Potential substance misuse,
- Patients who may need to remain on small doses e.g serious physical illness, severe mental health problems (for this you will need to be under secondary care, and we receive regular correspondence)
- Patients suitable for managed withdrawal

Please check the box below

I confirm that I understand the above statement ☐

Important note:

If you do not attend (DNA) your "New Patient Health Check" and do not contact the practice within 2 weeks to re-book your appointment your application to register with this practice will be cancelled, subject to waiting times, your new application will then need to be re-submitted.

Please check the box below

I confirm that I understand the above statement ☐

Declaration

I declare that the information I have given on this form is correct to the best of my knowledge.

Patient Signature:

Date:

Please use checklist on page 9, attach ID requirements needed for a successful registration.

Please complete the following screening questionnaire tool for alcohol use.

Please select with an X.

Scoring	0 points per question	1 point per question	2 points per question	3 points Per question	4 points Per question
1)How often do you have a drink containing alcohol?	Never: ☐	Monthly or less: ☐	2 – 4 times a month: ☐	2 – 3 times a week: ☐	4 or more times a week: ☐
2)How many drinks do you have containing alcohol on a typical day when you are drinking	0 – 2 ☐	3-4 ☐	5 – 6 ☐	7 – 9 ☐	10 or more ☐
3)How often do have four or more drinks on one occasion?	Never: ☐	Less than monthly: ☐	Monthly: ☐	Weekly: ☐	Daily or almost daily: ☐
4)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: ☐
5)How often in the last year failed to do what was normally expected of you because of your drinking session.	Never: ☐	Less than monthly: ☐	Monthly: ☐	Weekly: ☐	Daily or almost daily: ☐
6)How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session.	Never: ☐	Less than monthly: ☐	Monthly: ☐	Weekly: ☐	Daily or almost daily: ☐
7)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: ☐
8)How often during the last year have you been unable to remember what happened the night before because of your drinking.	Never: ☐	Less than monthly: ☐	Monthly: ☐	Weekly:☐	Daily or almost daily: ☐
9)Have you or someone else have been injured because of your drinking.	No: ☐		Yes, but not in the last year: ☐		Yes, in the last year: ☐
10) Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down.	No: ☐		Yes, but not in the last year: ☐		Yes, in the last year: ☐
Add the score for each column =		+	+	+	+

Total Score (add column scores) = _____

Understanding your results:

1-7 = low-risk drinking
8-15 = hazardous drinking
16-19 = harmful drinking
20 + = possible dependence

Summary Care Record Patient Consent Form

Having read the information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

Or

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of Patient: _____

Address: _____

Postcode: _____ Date of Birth: _____

NHS Number (if known): _____

Signature: _____ **Date**:

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: _____

Please select one: Parent: ☐ Legal Guardian: ☐ Lasting power of attorney for health and welfare: ☐

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.