New Patient Registration Form

PATIENT INFORMATION			
Surname:			
Forenames:			
Date of Birth:	/ /		
Address:			
Postcode:			
Home telephone number:		Mobile telephone number:	Work telephone number:

Preferred contact telephone number: ❑ Home ❑ Mobile ❑ Work ❑ Other _____

Do you wish to register for SMS text message reminders for appointment times and other appropriate matters relating to your care? ❑ Yes ❑ No

Next of Kin:	Relationship of next of kin:
	Telephone number of next of kin:

Do you require the assistance of an interpreter? ❑ Yes ❑ No

If yes, please indicate which language you require:

If registering a minor (under 18 years), please provide details of school/College currently attending

Name of School/College:	
Address:	
Postcode:	

Do you look after someone?

The practice is trying to identify and support as many Carers (unpaid) as we can. This includes helping a family member, friend or neighbour because of their physical, mental ill health, frailty, learning disability or substance misuse with tasks such as helping with cooking/cleaning, taking to appointments, collecting prescriptions, administering medication and any other support related tasks.

Yes I am a Carer ☐ No I am not a Carer ☐

Someone cares for me ☐ Name: _____

Registering as a Carer with us will entitle you to a free annual flu vaccination and annual health check as well as giving you access to lots of other free support and services.

Please ask at Reception for a FREE Carers pack.

FAMILY HISTORY (IF KNOWN)

	If living, present age	State of health	If deceased, age at date of death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Have any members of your family suffered from diabetes, high blood pressure, mental disorder, heart disease, kidney trouble, cancer, bowel disease or stroke?

❑ Yes ❑ No If yes, please give details:_____

Do you have, or have you ever had a Social Worker involved with your family? ❑ Yes ❑ No

MEDICAL HISTORY QUESTIONNAIRE

Have you ever sought medical advice or received treatment for any of the following:

	Yes	No	Please give details
Anaemia/abnormal bleeding problem			
Respiratory problem			
Heart murmur/heart surgery			
High/low blood pressure/stroke			
Liver problems or jaundice			
Kidney problems			
Diabetes			
Epilepsy/blackouts or fainting			
Immunosuppressive disorders			

Any known allergies? ❑ Yes ❑ No If yes, please give details: _____

Are you pregnant? ❑ Yes ❑ No If yes, please indicate EDD: _____

	Never smoked	Ex-smoker	Smoker
Smoking status:			

	Light	Moderate	Heavy
Weekly exercise:			

Height:	
Weight:	
Blood pressure reading:	

Please inform us of anything that you feel is medically necessary:

Do you have any special communication needs? _____

Are you happy for us to share this information with other healthcare providers? ❑ Yes ❑ No

For office use:

ID checked:

Driving licence/passport/other _____

Please help us by providing information about your ethnic group

Why we are collecting information about your ethnic group?

Everyone belongs to an ethnic group, so all of our patients are being asked to describe their ethnic group. We are collecting this information to help the NHS and Social Services to:

- **Understand the needs** of patients and service users from different groups and so provide better and more appropriate services for you
- **Identify risk factors-** some groups are more at risk of specific diseases and care needs, so ethnic group data can help treat patients and support services users by alerting staff to high-risk groups.
- **Improve public health** by making sure that our services are reaching all of our local communities and that we are delivering our services fairly to everyone who needs them.
- **Comply with the Law** as the Race Relations (Amendment) Act 2000 gives public authorities a duty to promote race equality and good race relations, and ethnic monitoring is important in making sure that the race discrimination is not taking place.
- The 16 ethnic groups used are standard categories for collecting ethnic group information. Using these codes will help us to compare information about the groups using our services with information from the census which tells us about our local population.

The list of groups is designed to allow most people to identify themselves. The list is not intended to leave out any groups of people but to keep the collection of ethnic information simple. It is important to us that you are able to describe your own ethnic group.

If you need to complete any of the boxes labelled' any other group', then please give some details so that we can better understand your needs.

You do not have to complete the question but providing this information is very important. It will help us with diagnosis and assessment of your needs and it will also help us to plan and improve our service. The information you provide will be treated as part of your confidential NHS record. The NHS and Social Services have strict standards regarding Data Protection and your information will be carefully safeguarded.

If you have any concerns or questions regarding this request or want to make any comments or complaints about the collection of this information or the way in which you have been treated by staff requesting this information please contact the Practice Manager.

<u>The Department of Health has asked us to record the ethnic origin of all new patients</u>

This information will be added to your medical record.

If you do not wish to provide this information, please tick the information refused box at the end of the list.

Name	
Date of birth	

<u>Ethnic Origin</u>

Please tick the description which you feel is most appropriate

White - British	
White - Irish	
Other White background	
Mixed – White and Black Caribbean	
Mixed – White and Black African	
Mixed – White and Asian	
Other Mixed background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Other Asian background	
Black or Black British – Caribbean	
Black or Black British - African	
Other Black background	
Chinese	
Other ethnic background	
Information refused	

AUDIT - C

Name: _____

Please tick the applicable boxes below.

	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often do you have a drink containing alcohol?					

	1 - 2	3 - 4	5 - 6	7 - 9	10+
How many units of alcohol do you drink on a typical day when you are drinking?					

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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?					

For office use:

Scoring

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT – C positive.

Scoring system	0	1	2	3	4

Linden Medical Group Online Patient Participation Group registration form

Would you be interested in being part of a virtual community of Linden Medical Group Patients, whose views and opinions can help shape the future of services provided by this practice?

The Patient Participation Group at Linden Medical Group has been in existence for a number of years and the virtual group is simply an extension, which will hopefully reach out into the wider patient population.

By joining the Online Patient Participation Group, you will receive updates on any changes to services or procedures and from time to time, be invited to complete questionnaires to help the Practice understand if different or additional services should be considered in the future.

To join you will need to be a registered patient here at Linden Medical Group, have a current email address and access to the Internet. Simply complete the registration form below and overleaf and await further details. Please note that your email address will only be used for Patient Participation Group purposes. Your email address will not be linked to your medical records.

Name:	
Date of birth:	
Email address:	

I confirm that I am a registered patient at Linden Medical Group and I consent to my email address being stored for the purpose of the Linden Medical Group Virtual Patient Participation Group.

Signed:	
Date:	

Please provide the following information by ticking the relevant boxes.
This information will only be used to monitor the demographic make-up of the Patient Participation Group.

Male	Female

	17-24	25-34	35-44	45-54	55-64	65-74	75-84	Over 85
Age Group:								

Ethnic Background

White British	White Irish	White/ Black Caribbean	White/ Black African	White/ Asian	Indian	Pakistani	Bangladeshi	Caribbean	African	Chinese	Other

	Regularly	Occasionally	Very Rarely
Frequency of visits to the Practice:			

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....