EDENFIELD ROAD SURGERY

PLEASE ENSURE THAT THE REGISTRATION FORM AND QUESTIONNAIRE ARE COMPLETED FULLY.

WE CANNOT ACCEPT INCOMPLETE REGISTRATION FORMS

NEW PATIENTS ARE ALSO REQUIRED TO PROVIDE EVIDENCE OF ADDRESS AND IDENTITY.

E.G: CURRENT DRIVING LICENCE, CURRENT UTILITY BILL, BANK STATEMENT

Surname:_____ Maiden Name_____

Fornames:_____ Marital Status_____

D.O.B_____ Telephone Number _____

Address_____

_____

_____Postcode_____

Ethnic Group (which of the following ethnic group do you fall into?) please Circle one.

White

British

Irish

Any other white background (please state)

MIXED

White & Black Caribbean

White & Black African

White Asian

Any other mixed background (please state)

ASIAN

Indian

Pakistani

Bangladeshi

Any other Asian background (please state)

BLACK OR BLACK BRITISH

Caribbean

African

Any other Black background (please state)

CHINESE OR OTHER ETHNIC GROUP

Chinese

Any other (please state)

MAIN LANGUAGE SPOKEN (please circle)

English	Punjabi	Urdu	Bengali
Hindi	Kurdish	Arabic	Polish

Other (please state)

PAST MEDICAL HISTORY

Please tick and add date if you have had any of the following:-

CONDITION	**YES**	**NO**	**DATE/YEAR DIAGNOSED**
Asthma			
COPD			
High blood pressure			
Heart Failure			
Atrial Fibrillation			
Stroke/TIA			
Angina			
Heart Attack			
Coronary bypass			
Type 1 Diabetes			
Type 2 Diabetes			
Prediabetes			
Gestational Diabetes			
Chronic Kidney disease			
Depression			
Other mental health Problems			
Epilepsy			
Learning Disability			
Over or under active thyroid			
Dementia			
Any operations or health conditions :			

Do any of the above conditions run in the Family?

_____

_____

Do you have any allergies?_____

_____

Social History

What is your Job? _____

Smoking History (please circle) Never Smoked

Ex-Smoker

Current Smoker

Weekly Alcohol intake _____units per week

Height _____

Weight_____

Date of last Smear (women)_____

Medications

Please list all medications and dosage or attach a recent prescription from previous surgery

MEDICATION	DOSAGE

Thank you for filling in this form. The information will help us to provide you with better and more appropriate care, with regular follow-up as necessary.

Next of Kin

Please provide details of your next of kin.

SURNAME	FORENAME	TELEPHONE NUMBER

Military Veterans

Are you a Military Veteran? (please circle)

Yes No

Do you agree to this being recorded in your medical records?(please circle)

Yes No

Signature _____ Date_____

Children Under 18

Surname	Previous Surnames	Forenames	D.O.B	Current School/Nursery

ALL NEWLY REGISTERED CHILDREN UNDER THE AGE OF 18 ARE ENTITLED TO A NEW PATIENT CHECK

Do you require this (please circle) if yes, please an appointment with the Practice Nurse once you are registered.

Yes No

Adults over 18

Please name all adults over 18 living at the same address

Surname	Fornames	D.O.B

Information for new patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

c) **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient

Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record Patient Consent Form

Having read the above 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 circle 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.

The Alcohol Use Disorders Identification Test (AUDIT)

Take the AUDIT Test

1. How often do you have a drink containing alcohol?
(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) 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?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of
drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or
suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

The World Health Organization developed the Alcohol Use Disorders Identification Test (AUDIT) in 1982. The AUDIT has proven to be accurate across all ethnic and gender groups and is one of the most accurate alcohol screening tests available (92% effective) in detecting hazardous or harmful drinking.

A total score of less than 8 indicates no harmful drinking behavior or alcohol dependence.
A total score of 8 or more indicates harmful drinking behavior.
A score of 13 or more in women is likely to indicate alcohol dependence.
A score of 15 or more in men, is likely to indicate alcohol dependence.