

HAWTHORNS SURGERY

NEW PATIENT REQUEST TO JOIN PRACTICE LIST (OVER 18)

Please complete and return this questionnaire together with 2 forms of identification.

- Passport or photo driving licence or National Identity Card.
- Bank/Building Society statement or utility bill (less than 3 months old) showing home address.

ID Verified By: (Office use only) Date:

Date of NP Screening Appointment: (Office use only)

Have you been registered with this surgery in the past? Yes No If yes, with whom?

Your Nominated/Allocated GP is your Registered GP.

PATIENT DETAILS

MR MRS MS MISS MALE FEMALE Marital Status

SURNAME: PREVIOUS SURNAMES:

FORENAMES: DOB:

NHS Number: Place of Birth:

Current Address:

Postcode:

Home Phone Number: Mobile Number:

We sometimes contact our patients via text message for appointment reminders/recalls etc.

Please tick the box to consent you agree for us to contact you in this way (you retain the right to opt out at any time) YES (#9NdP – For Office Use) Or NO Do not contact me by SMS messaging. (#9NdQ – For Office Use)

Work Number: Email Address:

IMPORTANT - Please help us trace your previous medical records by providing the following information:

Previous Address in UK:

Previous Doctor:

Surgery Address:

If You Are From Abroad:

FIRST UK ADDRESS WHERE REGISTERED WITH A GP:

IF PREVIOUSLY RESIDENT IN UK, DATE OF LEAVING:

DATE YOU FIRST CAME TO LIVE IN UK.

Details Of Any Last Adult Vaccinations:

When was your last Tetanus? When was your last Flu Jab?

When was your last Pneumococcal jab? When was your last Shingles jab?

Any Travel Vaccinations? List with dates if possible.

HAWTHORNS SURGERY

WHICH OF THE FOLLOWING STATEMENTS DESCRIBES YOU. PLEASE TICK ONE BOX.

ETHNIC STATUS						
WHITE		MIXED		BLACK OR BLACK BRITISH	ASIAN OR ASIAN BRITISH	OTHER ETHNIC GROUPS
British		White & Black Caribbean		Caribbean	Indian	Chinese
Irish		White & Black African		African	Pakistani	Any Other Ethnic Group
Any Other White Background		White & Asian		Any Other Black Background	Bangladeshi	
		Any Other Mixed Background			Any Other Asian Background	

IF YOU ARE RETURNING FROM THE ARMED FORCES:

ADDRESS BEFORE LISTING:

.....

SERVICE OR PERSONAL NUMBER:

ENLISTMENT DATE:

DISCHARGE DATE:

NHS ORGAN DONATION: The law on organ donation has changed. It will now be considered that you agree to be an organ donor if you are over 18 and (a) have not 'opted out' or (b) you are not in an excluded group. There is helpful information about organ and tissue donation on the website: organdonation.nhs.uk and on social media @NHSOrganDonor. You can also call the dedicated helpline: 0300 303 2094.

NHS BLOOD DONOR REGISTRATION:

I would like to join the NHS Blood Donor Register as someone who may be contacted and be prepared to donate blood.

SIGNATURE CONFIRMING CONSENT FOR INCLUSION ON THE BLOOD DONOR REGISTER

DATE:

HAVE YOU GIVEN BLOOD IN THE LAST 3 YEARS? YES NO

HAWTHORNS SURGERY

HEALTH QUESTIONS:

1.	What Is Your Smoking History? <i>If you are interested in giving up smoking, you can book an appointment at Reception for free and confidential support from experienced advisors.</i>	Never Smoked	
		Ex-Smoker	
		Current Smoker	
2.	What Is Your Height? (Feet or Metres)		
	What Is Your Weight? (Stones or kg)		
3.	Are You A Main Carer For Anyone? <i>A carer, without being paid, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability. If Yes, please ask for a Carers' Information Pack and a Carers' Form at Reception.</i>	Yes	
		No	
4.	Does Someone Care For You? <i>If so, please enter details on page 6.</i>	Yes	
		No	
5.	Women Aged 25 – 65 Years: When did you have your last cervical smear?	Date:	
6.	Women Aged 50 – 64 Years: When did you last have your breast screening?	Date:	
7.	Have you had a hysterectomy? If yes, give date.	Date:	
8.	Do you have a coil fitted? If yes, give date.	Date:	
9.	Next of Kin: Separate form available from Reception. If you wish us to record NOK for data protection and confidentiality purposes.		
10.	Please name any drug or medication taken regularly (including "the pill") and attach a copy of your repeat prescription. You will need to book an appointment with the GP for you first prescription. Please advise Receptionist that you are a new patient and need first prescription. Please advise us of details if you currently have a nominated pharmacy who deals with your prescription requests.		
11.	Are you allergic to anything? Please give details (especially drug allergies).		

FAMILY HISTORY: Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

Problem	Their Relationship To You	Their Age When Illness Started
Heart Attack		
Angina		
Stroke		
Asthma		
Diabetes		
Cancer (<i>State type, eg. bowel, breast</i>)		

PERSONAL HISTORY: Your full Medical Record will be sent to us from your last practice in due course. However, in the meantime, it is important that we know about the following:

		Yes	No
1.	Are you Diabetic?		
2.	Have you ever had a Heart Attack?		
3.	Have you ever had Angina?		
4.	Have you ever had a Stroke or Transient Ischaemic Attack (TIA) sometimes called a 'mini stroke'?		
5.	Do you take medication for an Under-Active Thyroid Gland (Hypothyroidism)?		
6.	Are you on treatment for Blood Pressure (Hypertension)?		
7.	Do you have Chronic Obstructive Pulmonary Disease (COPD)? This is a disease requiring regular use of inhalers but is not Asthma.		
8.	Do you take medication for Epilepsy?		
9.	Do you have Asthma?		
10.	Have you recently been diagnosed with Cancer or any other serious or life-threatening disease not mentioned above?		

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ON LINE SERVICES

Did you know?

You can book appointments and order repeat medication on line.

Application forms available at Reception or on our website via the on line services tab.

If you wish to view a summary of your Medical Records on line please complete an application form available at Reception or on our website via the on line services tab.

(Currently only therapy, allergies and contraindications available to view).

A token can be emailed to you from the Surgery after 5 working days.

Also, Did You Know, you can go into a pharmacy of your choice and nominate them for EPS – Electronic Prescription Service. This means your prescription will go directly to that pharmacy for your convenience.

SUMMARY CARE RECORD

How We Use Your Data:

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP Practice is closed. If you are happy for us to make a Summary Care Record for you please tick the **Yes** box. If you do not want us to make a Summary Car Record for you, please tick **No**.

Further information on what this means to you can be found at www.nhscarerecords.nhs.uk or by phoning 0300 123 3020 where you can find information in other formats and languages.

This part of the application form must be completed or it will delay your registration.

Yes

No

SIGNATURE OF PATIENT:

.....

SIGNATURE ON BEHALF OF PATIENT:

.....

PRINT NAME:

.....

HAWTHORNS SURGERY

ALCOHOL SCREEN: Please complete for each patient over 18 years of age registering.

NAME: **DOB:** **DATE:**

Please circle the answer that is correct for you.

These questions ask about the alcohol you have drunk in the last 6 months. The questions ask about how many standard drinks you have consumed. Please note that 1 standard drink = 1 unit of alcohol. So, for example, a pint of regular beer or lager is equal to 2 standard drinks or 2 units.

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or Less	2-4 Times Per Month	2-3 Times Per Week	4+ Times Per Week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 -4	5 -6	7 – 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily	
How often in the last year have you found you were not able to stop drinking once you had started?	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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily	
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	
Have you or someone else been injured as a result of your drinking?	No		Yes But Not In The Last Year		Yes During The Last Year	
Has a relative/friend/doctor/health worked been concerned about your drinking or advised you to cut down?	No		Yes But Not In The Last Year		Yes During The Last Year	
					TOTAL SCORE	

SCORING:

0-7 = Sensible Drinking
16-19 = Harmful Drinking

8-15 = Hazardous Drinking
20+ = Possible Dependence

HAWTHORNS SURGERY

The Accessible Information Standard aims to ensure that patient (or their carers) who have a disability or sensory loss can receive access and understand information, for example, in large print, braille or via email and professional communication support if they need it, for example, from a British Sign Language interpreter.

This applies to patients and their carers who have information and/or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and/or communication needs, where appropriate. Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and/or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

	Yes	No
• Do you have communication needs?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you need a format other than standard print?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have any special communication requirements?	<input type="checkbox"/>	<input type="checkbox"/>

If Yes

- What is your preferred method of communication?
 - How would you like us to communicate with you?
 - Can you explain what support would be helpful?
 - What is the best way to send you information?
 - What communication support could we provide for you?
-

NAME: DOB:

	Yes	No
If you have a carer do they need communication assistance?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, what is your main carer's name:	<input type="checkbox"/>	<input type="checkbox"/>
Do you consent to the Practice contacting your main carer regarding your care?	<input type="checkbox"/>	<input type="checkbox"/>
Which is the best way to contact them?	<input type="checkbox"/>	<input type="checkbox"/>