HAWTHORNS SURGERY

NEW PATIENT REQUEST TO JOIN PRACTICE LIST (UNDER 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 of NP Screening Appointment: ……………………………………………………… (Office use only)

Your Nominated/Allocated GP is your Registered GP. Date: ………………………

Have you been registered with this Practice in the past? Yes ☐ No ☐ If yes, with whom? …………………………………..

Patient Details:

MR ☐ MRS ☐ MS ☐ MISS ☐ MALE ☐ FEMALE ☐ Marital Status ……………………………………

SURNAME: ………………………………………………….. PREVIOUS SURNAMES: ……………………………………………

FORENAMES: ……………………………………………………………………………………….. DOB: ……………………………….

(***For children aged 5 years and under*** please supply vaccination details below and parent details as this will be passed on to our Health Visiting Team).

Parent Details:

Mother's Name: …………………………………………………. Father's Name: ……………………………………………………..

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: …………………………………………………………

Name of Child's School *(if applicable)*: ……………………………………………………………………………………………

Details of Routine Childhood Vaccinations (Aged 5 years and under). You may prefer to supply a copy of their 'Red Book' personal child health record.

………..

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:

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: ………………………………………………

<u>NHS ORGAN DONOR REGISTRATION</u>:

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

(Please tick as appropriate)

Kidneys		Heart		Liver		Corneas		Lungs		Pancreas		Any Part Of My Body	

SIGNATURE CONFIRMING CONSENT TO ORGAN DONATION ………………………………………………………………………………………

DATE: ………………………………………………………

<u>NHS BLOOD DONOR REGISTRATION</u>:

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 ☐

HEALTH QUESTIONS:

1.	**What Is Your Smoking History?** *If you are interested in giving up smoking, you can book an appointment at Reception for free and confidential support from experienced advisors.*	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 Or Does Someone Care For You?** *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.*	Yes No	
4.	**Women Aged 25 – 65 Years:** When did you have your last cervical smear?	Date:	
5.	**Women Aged 50 – 64 Years:** When did you last have your breast screening?	Date:	
6.	Have you had a hysterectomy? If yes, give date.	Date:	
7.	Do you have a coil fitted? If yes, give date.	Date:	
8.	**Next of Kin:** Separate form available from Reception. If you wish us to record NOK for data protection and confidentiality purposes.		
9.	Please name any drug or medication taken regularly (including "the pill") but note you will need to **book an appointment with the GP for you first prescription. Please advise us of details if you currently have a nominated pharmacy who deal with your prescription requests.**		
10.	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 (*State type, eg. bowel, breast)*		

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 serous or life-threatening disease not mentioned above?		

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.

1. How often do you have a drink containing alcohol?				
Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times per week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?				
1 or 2	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
3. How often do you have six or more drinks on one occasion?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
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	Two to three times per week	Four or more times per week
5. How often during the last year have you failed to do what was normally expected from you because of drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
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	Two to three times per week	Four or more times per week
7. How often during the last year have you had a feeling of guilt or remorse after drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
8. 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	Two to three times per week	Four or more times per week
9. 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	
10. Has a relative or friend, or a doctor or other health worked, been concerned about your drinking or suggested you cut down?				
No	Yes, but not in the last year		Yes, during the last year	

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?		
• Do you need a format other than standard print?		
• Do you have any special communication requirements?		

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?		
If Yes, what is your main carer's name:		
Do you consent to the Practice contacting your main carer regarding your care?		
Which is the best way to contact them?		