Desborough & Hazlemere Surgery

THIS IS A NEW PATIENT REGISTRATION FORM FOR ADULTS

- **THIS FORM IS NOT FOR TEMPORARY REGISTRATION**
- **THIS FORM IS NOT FOR CHILDREN 0-16 YEARS OLD**
- **NEW PATIENTS SHOULD BOOK AN APPOINTMENT AS SOON AS POSSIBLE FOR A HEALTH CHECK WITH A MEMBER OF THE HEALTHCARE TEAM TO ENSURE THAT ANY REQUIRED TESTS ARE UP TO DATE AND THAT WE HAVE AN ACCURATE NOTE OF ANY REPEAT MEDICATION YOU MAY BE TAKING**

WRITE ONLY IN CAPITALS

1. **BRING PROOF OF IDENTITY AND A PHOTOCOPY**
2. **BRING PROOF OF ADDRESS**
3. **COMPLETE A GMS1 FORM**
4. **COMPLETE THIS FORM AND RETURN ALL 8 PAGES**

HELPFUL PATIENTINFORMATION LEAFLETS, FORMS & OPT OUT DETAILS CAN BE FOUND AT:

WWW.DESBOROUGH.GPSURGERY.NET/PATIENT-INFO/NEW-PATIENT-REGISTRATION

For Official Use Only		
Date Completed		
Confirmation of address seen?		
First Appointment		
Appointment With		
If resident at a Care Home record Residential Institute (Registration Details/Other)		
Audit C Info	Completed YES/NO	Input YES/NO
Smoking Info	Completed YES/NO	Input YES/NO
Ethnicity Info	Completed YES/NO	Input YES/NO
Alcohol Info	Completed YES/NO	Input YES/NO
Forms Ready For Scanning		
SCR	SCRYES 9Ndm SCRNO 9Ndo	
MCR	Mycareyes 93C0 mycareno 93C1	

Desborough & Hazlemere Surgery

www.desborough.gpsurgery.net Twitter @desandhazgp

All Patients To Complete ALL Of The Following Sections + GMS1 Form

Temporary patients only need to complete a GMS3 form

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐Female

Mobile number:

Email address:

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital?
If so please enter details below:

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES**☐ **NO** ☐
If Asthmatic, have they used their inhaler in past 12 months?	**YES**☐ **NO** ☐		

Immunisations ……

Please bring in a copy of any previous vaccinations

Immunsation	Year	Immunisation	Year
Tetanus		1st MMR (Measles , Mumps or Rubella)	
Typhoid		2nd MMR	
Hepatitis A		Yellow Fever	
Polio		Hepatitis B	

If in doubt, it is recommended you arrange an appointment with the Nurse to have another immunisation as it is quite safe to do so.

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐No

If yes, do you smoke: ☐ Cigarette ☐Cigars ☐Pipe

Are you an ex-smoker? ☐ Yes ☐No

When did you give up? ☐

How many cigarettes/ cigars do you smoke daily? ☐<1/day ☐1-9/day ☐10-19/day ☐20-39/day ☐40+/day

If you smoke a pipe how many ounces a week? ☐

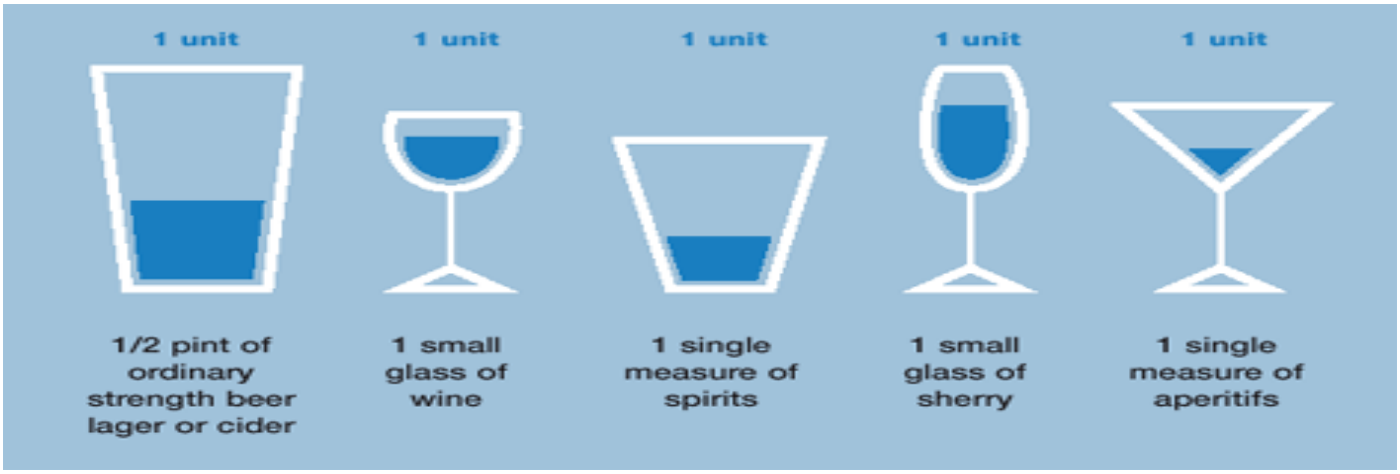
Would you like help to quit smoking? ☐ **Yes** ☐No

Lifestyle alcohol ……

Please complete if 16 years or over;

Do you drink alchol: ☐ **No** *go to page 6 Ethnicity* ☐ **Yes If** *yes answer the following questions*;

This is one unit of alcohol…



AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

A total of 5 or more indicates possible increasing or higher risk drinking.

An overall total score of 5 or above is **AUDIT-C** positive. **If your score is 5 or more please complete the next section for a complete AUDIT-C score**

SCORE

Remaining AUDIT-C questions (if you scored 5 or more)

Questions	Scoring system					Your score
	0	1	2	3	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	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
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	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total score, equals AUDIT C Score plus Score of remaining questions above;

Your total Audit Score = _____ (section 1+section 2)

0 -7	indicates sensible or lower risk drinking
8-15	indicates increasing risk drinking
16-19	indicates higher risk drinking
20 and over	indicates possible alcohol dependence

Please make an appointment with our practice nurse if your score is 8 or more.

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐Polish ☐African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Irish☐Bangladeshi ☐ Chinese

☐Other (please state):
☐ Decline to state

What is your first spoken language? _____ Do you need an interpreter? Y/N

Next of kin ……

Name:

Tel. contact number:

Relationship:

Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐No

Please contact reception to make an appointment with a Nurse

Please tell us about yourself:

Are you an unpaid carer? ☐ Yes (918A) ☐No
Do you have an unpaid carer? ☐ Yes (918F) ☐No

If yes, please tell us the name, address & DOB ofyour Carer or who you care for:

Are you happy for us to contact your carer about you? ☐ Yes ☐No

If you are a Carer, may we pass your details on to Carers Bucks who offer help & support? ☐ Yes ☐No

I give permission for my Carer to have access to my medical records held by the Practice

Signed_____

Date_____

For patients aged 85 or over ONLY: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐No
In general, do you have any health problems that require you to stay at home? ☐ Yes ☐No
Do you regularly use a stick, walker or wheelchair to get about? ☐ Yes ☐No
In case of need, can you count on someone close to you? ☐ Yes ☐No
Do you need someone to help you on a regular basis? ☐ Yes ☐No

Please provide details if the person is different from the information you have provided as your carer.

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

By submitting this registration form, you indicate your consent to opting-in for these services. If you do not want to receive the service use the opt-out forms indicated and return it to reception.

Data sharing consent choices

1. NHS England has introduced the **Summary Care Record (SCR)**, which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

   If you wish to **OPT OUT** please complete a SCR Opt-Out form on our website

2. Bucks have a new approach to sharing patient records between clinicians and other professionals who may provide your care. **My Care Record (MCR)** is a system that allows medical and social care professionals to access your up-to-date GP records so they can make the right choices about the care and medical attention you need.

   If you wish to **OPT OUT** please complete a MCR Opt-Out form on our website

3. Your mobile number and email address, may be used by the Surgery to contact you for the following reasons:

Text - to send you reminders for appointments, vaccinations, annual diabetes reviews, surgery closures etc.

Email- to send you personal letters, surgery newsletters and occasional questionnaires.

If you wish to **OPT OUT** please complete a Text/Email Opt-Out form on our website

Helpful patient information leaflets and opt-out forms can be found at:
www.desborough.gpsurgery.net/patient-info/new-patient-registration

I confirm that the information I have provided is true to the best of my knowledge.

Signature ……..……..

Date:

Signature of patient ☐ Signature on behalf of patient ☐

Checklist before coming in to the surgery;

1. Have you completed all relevant sections?
2. Have you signed all relevant sections?
3. Have you completed the GMS1 registration form?
4. Do you have 2 different forms of identification and a copy or your passport?