hurley group

FAMILY DOCTOR REGISTRATION SERVICES
ADULT

Dear patient

By answering the question on this form you will be helping us to deliver better services to you as an individual. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form fully. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, or have any queries regarding this form, please feel free to ask the reception team.

Thank you

Registration Details

Mr □ Mrs □ Miss □ Ms □ Other □ **Male □ Female □**

Surname _____ **DOB**_____/____/_____

First Name(s) _____

Previous Surname_____ **NHS Number** _____

Home Address

_____

_____

Town and Country of Birth

_____

Telephone Number: 020 _____ **Mobile Number** _____

Work Telephone Number: _____

E-mail Address (*this will only be used for surgery correspondence)* _____

Are you housebound? Yes □ No □

Name of Next of Kin_____ **Contact Number**_____

Relationship to the person _____

Please help us to trace your previous medical records by providing the following information;

Previous Address in the UK

_____

_____

Name and Address of your previous doctor

_____

_____

If you are from abroad

Your first UK address where you registered with a GP

_____

_____

Date you entered the UK _____

Employment Status
Please tick

Retired □ Student □ Unable to work □ Unemployed □ Employed as _____

If you have children of your own aged 16 years or under, please list their names and dates of birth below?

Names	**Date of birth**

Ethnic Status, Nationality & Language

What is your country of birth?

What is your main spoken language?

What language do you prefer to read?

What do you consider to be your national identity?

Do you need an interpreter or translator?

Please tell us your ethnic group by ticking the box

White British □
White Irish □
White Scottish □
White Welsh □

Asian or Asian British □
Bangladeshi □
Indian □
Pakistani □

Mixed Background □
White & Asian □
White & Black African □
White & Black Caribbean □

Black or Black British □
African □
Caribbean □

Chinese □
Vietnamese □

Any other background please write: _____

NHS Organ Donor Registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

□ Any of my organs and tissue or

□ Kidneys □ Heart □ Liver □ Corneas □ Lungs □ Pancreas □ Any part of my body

Signature confirming my agreement to organ/tissue donation:

_____ **Date:**_____

NHS Blood Donor Registration

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

Tick here if you have given blood in the last 3 years □

Signature confirming consent to inclusion on the NHS Blood Donor Register my agreement to organ/tissue donation:

_____ **Date:**_____

Medical Records

If you are registered with a GP practice in England, you will have a Summary Care Record (SCR) unless you have chosen not to have one. Your SCR contains the following basic information:

- the medicines you are taking
- your allergies
- bad reactions you may have to certain medicines

It also includes your name, address, date of birth and unique NHS Number which helps to identify you correctly.

An SCR is used in a number of healthcare settings and will provide healthcare professionals with any information they wouldn't otherwise have. For example, when you're visiting an urgent care centre or being admitted to a hospital, staff could view your SCR and discover you are on a particular medication or have allergies.

Do you give your consent to have a summary of your medical records shared on the National Data Base?

Yes / No

Would you like to have access to your medical records on-line? **Yes / No**

Would you like to be set-up to book appointments on-line? **Yes / No**

Would you like to be able to book your repeat prescriptions on-line? **Yes / No**

If you have answered yes to any of the above 3 questions, you will need to provide a photo ID for the reception team to issue you with a unique PIN number.

Carer Status

Are you a carer? i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental heath problem or for any other reason?

Yes □ No □

If you are a carer, please fill in the carers registration form in your registration pack. If you have not received one, please ask at reception.

Are you cared for?

i.e. Do you have a friend or relative who helps you live your day to day life?

Yes □ No □

If yes please give details of your carer's contact information:

Name _____

Contact Number: _____

Health Status

Please tick which applies to you

Smoking

Never Smoked □
Ex-smoker □ (if so how many did you smoke per day) _____ and the date you stopped _____

Current Smoker □

Cigarettes □ (how many a day?) _____
Pipe □ (how many a day?) _____
Cigars □ (how many a day?) _____
Rolling Tobacco□ (how many a day?) _____

Would you like us to help you stop yes/no

Alcohol Consumption

How many units do you drink a week _____ **units**

Height: _____ ***cm***

Weight: _____***kg***

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the Newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office coding _____**+** _____ **+** _____ **+** _____

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult □

Based on 1 unit = ½ pint of beer or 1 glass of wine (125 ml) or 1 single spirits

Questions	Scoring System 0	1	2	3	4	Your Score
How often did you drink alcohol in past year	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your score is above 1.						
How many standard alcoholic drinks do you have on a typical day when drinking	1-2	3-4	5-6	7-8	10+	
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	
In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
Total Score	Add up your total score and enter it in the box on the right ⇨ If you score 3 or more, please complete the next questionnaire					

If you have scored more than 3, please complete part 2 on the next page. If you have scored less than 3 please skip the next page and continue onto the Exercise question.

Alcohol Screening Part 2 – only complete if your score was 3 or more in the questionnaire above.

Questions PART 2	Scoring System 0	1	2	3	4	Your Score
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 drinking	1-2	3-4	5-6	7-8	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 that 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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advised you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
Total Score	**Add up your total score and enter it in the box on the right ⇨** **Scoring 8-15 = hazardous drinking, 15-19 = harmful drinking, 20 or more = possible dependence**					

Exercise

Do you exercise regularly? Yes/No

If yes,

a) How often do you usually exercise?
less than once a week ☐ up to three times a week ☐ up to 5 times a week ☐ more than 5 times a week ☐

b) How long does your exercise usually last?
less than 10 minutes each time ☐ less than 30 minutes each time ☐ 30 minutes or more each time ☐

Medical Conditions

Do you suffer from any of these conditions?

	Approximately when diagnosed / Year
Diabetes	Yes / No
High Blood Pressure	Yes / No
Stroke	Yes / No
Osteoporosis	Yes / No
If Yes have you ever had a Dexa Scan?	Yes / No
Epilepsy	Yes / No
Asthma	Yes / No
Allergies or Hay fever	Yes / No
Eczema	Yes / No
Depression and/or Anxiety	Yes / No
Cancer	Yes / No

If yes, please state which type eg. Breast, colon, lung

Please detail any other conditions you suffer from that are not mentioned above:

Medication

Are you taking any medication? **If so, please tell us what you are taking**:

Name of medication	**Dose of medication**

Nominated Pharmacy

You can nominate a pharmacy so that your prescriptions can go electronically to them; if you want this service please select from below:

- Salus Pharmacy (next door)
- Boots Pharmacy (Westfield)
- Other – please specify with address _____

Operations or Invasive Procedures

Have you had any operations in the past? If so, please give details in the space below.

Immunisations and Vaccinations

Have you had any vaccines in the last 10 years? If so, please list, please include seasonal flu vaccine.

Allergies

Do you have any allergies?

Medication	Food	Anything Else

Family History

Please let us know in this section of any illness that is in your family:

Disease	**Relative**
Heart Disease	
Stroke	
Hypertension	
Diabetes Type 1 or Type 2	
Asthma	
Cancer	
Any other	

Women's Health (this section is for women only)

Cervical Smears

Date Taken	**At GP / Clinic**	**Results**	**Recall Date**

Contraception
If you are using a form of contraception please list in the box below

Have you been screened for:

Chlamydia Yes / No If yes please tell us the date:
Breast Screening Yes / No If yes please tell us the date:

Liberty bridge road practice
40 Liberty Bridge Road
East village
Stratford
London E20 1AS
Telephone: 02084967000
www.libertybridgeroadgp.co.uk

Consent Form for receiving messages on contact telephone numbers

It is our Policy, that due to patient confidentiality, we are unable to leave voice messages on mobiles or home answering machines.
If you **WOULD** like to consent to either of the above, please sign the disclaimer below.

Name: _____

DOB: _____

Contact Telephone Numbers:

Home: _____

Mobile:_____

I give consent for messages to be left on my mobile telephone and my home telephone answering machine.

Date: _____

Signature: _____(Read-code: 9ndi)

I give consent for text messages to be sent to my mobile telephone

Date: _____

Signature: _____(Read-code: 9ndp)

It is your responsibility to keep us updated with your current contact details.

(EMISNQDE129 is read code for declined home telephone answerphone messages)
(EMISNQDE130 is read code for declined mobile telephone answerphone messages)
(9ndq is read code for Declined consent for text messages)

Liberty bridge road practice
40 Liberty Bridge Road
East village
Stratford
London E20 1AS
Telephone: 02084967000
www.libertybridgeroadgp.co.uk

Consent Form for communication via E-mail

It is our Policy, that due to patient confidentiality, we are only able to communicate certain types of data via E-mail.

We are able to deal with appointment scheduling, ordering repeat prescriptions and general administrative tasks.

Please note that **we are not** at able to manage medical clinical queries/information (such as blood results) via email.

If you **WOULD** like to consent, please sign the disclaimer below.

Name: _____

DOB: _____

E-Mail address: _____

Date: _____

Signature: _____ (Read-code: 9nds)

It is your responsibility to keep us updated with your current contact details.

(9ndy is read code for declined e-mail communication)

Thank you for taking time to complete this form.

Please ask at reception for a practice leaflet to explain the services we offer at our Practice

SIGNED: _____

DATE: _____

PATIENT DECLARATION

Anybody in England can register with a GP practice and receive free medical care from that practice.

The NHS is the UK's state health service which provides treatment for UK residents. Some services are free, other have to be paid for.

A person who is regarded as ordinarily resident in the UK is eligible for free treatment by a GP. A person is 'ordinarily resident' for this purpose if lawfully living in the UK for a settled purpose as part of the regular order of his or her life for the time being. Anyone coming to live in this country would qualify as ordinarily resident. Overseas visitors to the UK are not regarded as ordinarily resident if they do not meet this description. If you are not a 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

☐ **I confirm that I reside in the UK and am entitled to receive FREE NHS Treatment**

I declare that the information I give on this form is correct. I understand that if it is not correct, appropriate action may be taken against me

Signed:	Date
Print name:	

STAFF ONLY

PATIENT'S EMIS NUMBER: _____

TYPE OF PATIENT ID SEEN FOR ONLINE ACCESS: _____

ID SEEN BY: _____