GRAYS INN MEDICAL NEW PATIENT REGISTRATION FORM

PLEASE TAKE YOUR TIME TO COMPLETE THIS FORM, USING **BLOCK CAPITALS** AS INCOMPLETE OR ILLEGIBLE FORMS CAN NOT BE PROCESSED.

FULL NAME: _____

IF YOU DO NOT LIVE WITHIN OUR CATCHMENT AREA, WE WILL NOT BE ABLE TO PROVIDE ANY HOME VISITS. Please ask reception staff if you are not sure.

EMAIL ADDRESS: (Only provide if you consent to communication from the practice via email)

_____

SEX: (please tick as appropriate) Male ☐ Female ☐

ETHNIC GROUP: _____ classifies the ethnicity of a PERSON, as specified by the PERSON.
E.g. Asian or Asian British: - Indian, Pakistani, Bangladeshi

Main spoken Language_____ **any other Language**_____

Do you require an Interpreter? Yes ☐ **No** ☐ **Do you lip read or use BSL?** _____

Are you registered deaf or hard of hearing?_____**Do you wear a hearing aid?** _____

Next of Kin (This information is necessary in the event of an emergency)
No
Yes *If yes, what is their relationship to you* _____

Name/Contact details:_____

Can your medical record be discussed with this person in a case of emergency? Y/N

STUDENTS
Are you a Student? _____Where:_____

Studying?_____

IF YOU'RE PARENT OR GUARDIAN (PLEASE COMPLETE IN DETAIL)

Name: _____Relationship to child: Parent…….Guardian……..

Contact Number: _____

Social Worker_____ (if applicable)

Childs School Name: _____

Please take a photocopy of child's Immunisation Card or Red Book today if they have it, or please ask them to bring in ASAP.

Admin use only :
Is the patient registered in the catchment area? YES / NO (please use catchment tool to identify)
If no, please state: 'OOAR' in GP Message field when registering.

Documents checked: ID ☐ Address Checked: ☐ Documents used:_____
Checked by_____

Where/How did you hear about the surgery?_____

The following questions are validated as screening tools for alcohol use

Do you drink alcohol? NO YES (please circle appropriate)
If yes, how many units do you drink per week? _____
(Please note: One pint of beer / lager = 2.3 units. One pub measure (25 ml) of spirits = 1 unit. One standard glass of wine (175 ml) = 2 units. One pint of strong cider = 4.7 units.)

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	
					TOTAL :	

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (after completing 3 AUDIT-C questions above)	**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 :	

Smoking Status
What is you current smoking status? (please circle appropriate)

SMOKER EX-SMOKER NON SMOKER

If cigarettes how many per day? _____
If tobacco how many Oz per week? _____

Have you seriously considered giving up? YES/NO
Would you like to see our in house smoking cessation adviser about quitting smoking? YES / NO
(NOTE FOR RECEPTION: please code appropriately if ptn is a smoker)

Are you a Carer? YES / NO
i.e. Do you look after somebody who is dependent on you? They could be a friend or relative. PARENTS are not counted as carer. The practice documents parents details in a different manner, in the childs records.

Do you have a Carer? YES / NO (PARENTS ARE NOT COUNTED AS CARERS)
i.e Are you dependent on a family member or friend? If so what are their detail? (The practice will record the name and contact details in your medical records

NAME_____ **Telephone Contact**_____

Information and Communication Needs

To help the practice meet the needs of our patients, we would be grateful if you could answer the below:
Do you have any Communication/ Information needs relating to disability, impairment or sensory loss, and if so, what are they? _____

_____

How can the practice meet your needs?_____

_____

Do you give the practice consent to share this information with other NHS providers and adult social care when required? _____

Your personal and family medical history

(Please tick as appropriate)

Have you or a family member had any of the following conditions?

Diagnosis	You	Family member and Relationship to you
Heart Disease/IHD <55yrs Male	Y/N	
Heart Disease/IHD >65yrs Female	Y/N	
CVA/Stroke	Y/N	
Diabetes	Y/N	
Asthma	Y/N	
Cancer Type:	Y/N	**Type:** **Relationship:**

Other illnesses, accidents or operations:
Please give details of any of the above, including dates if possible.
_____
_____

WOMEN ONLY

When was your last cervical smear? _____

What was the result? _____

If you have had your smear privately in the last 3-5 years please provide the surgery with the paperwork confirming. This will avoid unnecessary recall to have your smear at the practice.

DATA SHARING

Please read and make your selection by ticking the box or boxes next to the right statement. Then please fill out the required information below, sign and date the form and return it to reception.

Recording Consent of New Patients for Data Sharing Initiatives in Camden		
Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care. **PLEASE READ ATTACHED INFO**	I want to: Opt in to CIDR. ☐ Opt out of CIDR. ☐ **IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM ATTACHED.** **ADMIN- do not code opt put.**
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐
Care.data National Initiative	Care.data aims to make increased use of information from medical records with the intention of improving healthcare via research. Data Used for Information purpose. None patient Identifiable	I want my medical record to be part of Care.data. ☐ There are **2 levels of opt out**, you can opt out of both: I do not want my personal and confidential data to leave the Health and Social Care Information Centre ☐ I do not want my personal confidential data to leave the GP Practice ☐

Name: ----------

Date of Birth: ----------

Signature: ---------- **Date:** ----------

PLEASE COMPLETE IF YOU STATED THAT YOU WOULD LIKE TO OPT OUT ON THE DATA SHARING PAGE

CIDR Integrated Care Record

NHS Camden Clinical Commissioning Group

Please complete ALL sections in Part A and Part B.

Part A: Personal Details

Please complete in BLOCK CAPITALS for the relevant Service User / Patient.

Title:		**NHS Number:**	
Forename:			
Surname:			
Address:			
Postcode:		**Date of Birth:**	

Part B: Opt-Out of CIDR

(Please tick)

I do not consent to have a CIDR record created. ☐

I confirm that I understand the impact of this request.

Signed:		**Date:**	

PLEASE HAND BACK TO THE RECEPTIONIST ON COMPLETION