PUTNEYMEAD GROUP
MEDICAL PRACTICE

U.K RESIDENTS REGISTRATION FORM

For Office Use:
Receptionist Initials:
EMIS Number:

Please write in clear <u>BLOCK CAPITAL LETTERS</u> and ✓ as appropriate

<u>Patient's details:</u>

NHS Number (if known):

Title: MR ☐ MRS ☐ MISS ☐ MS ☐ OTHER ☐ if other, please state:

Surname:

First Name:

Middle Name(s):

Previous Surname:

Date of Birth: / /

Country of Birth:

Town of Birth:

Gender: FEMALE ☐ MALE ☐

Main Language:

Translator Required? YES ☐ NO ☐

Date of Entry into UK: / /

Home Address:

Postcode:

Previous Home Address:

Postcode:

Email Address:

Home Telephone Number:

Mobile Number:

I, consent to receive text notifications for clinical services. YES ☐ NO ☐

Please turn overleaf

THIS INFORMATION IS REQUIRED TO ALLOW US TO TRACE YOUR PREVIOUS MEDICAL RECORDS – PLEASE FILL IN ALL BOXES

Name of Previous GP: (e.g. Dr. Jones)

Name of Previous GP Practice: (e.g. Churchill Medical Practice)

Address of Previous GP Practice:

Town/City:

County:

Postcode:

IF YOU ARE RETURNING FROM THE BRITISH ARMED FORCES:

Address before Enlisting:

Town/City:

County:

Postcode:

Service Number:

Enlistment Date: / /

NEXT OF KIN (NOK) / EMERGENCY CONTACT DETAILS:

Title: MR ☐ MRS ☐ MISS ☐ MS ☐ OTHER ☐ if other, please state:

Surname:

First Name:

Relationship:

Home Telephone Number:

Mobile Number:

Work Telephone Number:

IN THE EVENT OF AN EMERGENCY, CAN WE CONTACT THIS PERSON? YES ☐ NO ☐

Signature:

Date: / /

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this Questionnaire, along with any other information you feel we should know.

ALL INFORMATION IS TREATED IN STRICT CONFIDENCE

How TALL are you? _____ cm How much do you WEIGH? _____ kg

_____ ft/Inches _____ st/lbs

Blood Pressure Reading ☐ / ☐ We provide access for self-monitoring your blood pressure in the 'Pod Room'. This is located on the first floor**.** ***Please bring your reading to Reception.***

SMOKING HISTORY: Current Smoker ☐ Ex-Smoker ☐ Never Smoked ☐

Please circle: Cigarettes Tobacco Cigars Pipe

Ex-Smoker: When did you stop smoking (DD, MM, YYYY)? _____

We pride ourselves on helping, supporting and actively encouraging Smokers to 'Quit' and can provide one to one in-house support and therapy. Would you like one of our smoking cessation advisers to contact you?

Yes ☐ **No** ☐

Are you **ALLERGIC** to any medications e.g. Penicillin or Aspirin? If yes, please state:

Please list any **SERIOUS ILLNESS** or **OPERATION** you have had, and the year that it occurred:

Please bring in a copy of any **REPEAT PRESCRIPTION** to your first GP appointment.

If applicable, please note the Date, Location and Result of your last **CERVICAL SMEAR** test:

WE ENCOURAGE PATIENTS TO SIGN UP TO **PATIENT ACCESS**. THIS ALLOWS PATIENTS TO MAKE APPOINTMENTS, VIEW RESULTS AND ORDER REPEAT PRESCRIPTIONS ONLINE. TO SIGN UP FOR ONLINE ACCESS, PLEASE BRING PHOTO IDENTIFICATION TO THE PRACTICE **WITHIN 48 HOURS**, ONCE YOUR REGISTRATION HAS BEEN PROCESSED.

NHS ORGAN DONOR REGISTRATION

I want to register my details on the **NHS Organ Donor Register** as someone who may permit my Organs/Tissue to be used for transplantation after my death*. Please tick the boxes that apply*:

Any of my organs and tissue ☐	Heart ☐	Liver ☐	Corneas ☐	Lungs ☐
Pancreas ☐	Any part of my body ☐	Signature_____ 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. ☐ **YES**

SIGNATURE CONFIRMING CONSENT TO INCLUSION ON THE NHS BLOOD DONOR REGISTER

SIGNATURE _____ DATE_____

Please turn overleaf

NEW PATIENT HEALTH QUESTIONNAIRE CONTINUED

Please help us plan for the future Healthcare of our population by providing information on your ethnicity.

Please circle ONE only

WHITE	BRITISH
	IRISH
	ANY OTHER WHITE BACKGROUND
MIXED	WHITE AND BLACK CARRIBEAN
	WHITE AND BLACK AFRICAN
	White and ASIAN
	ANY OTHER MIXED BACKGROUND
ASIAN OR ASIAN BRITISH	BANGLADESHI
	INDIAN
	PAKISTANI
	ANY OTHER ASIAN BACKGROUND
BLACK OR BLACK BRITISH	CARRIBBEAN
	AFRICAN
	ANY OTHER BLACK BACKGROUND
OTHER ETHNIC GROUPS	CHINESE
	ANY OTHER ETHNIC GROUP
DECLINES TO PROVIDE ETHNIC GROUP	

Please check with Reception, if you're out of area.

OUT OF AREA DECLARATION

Please be aware that you live outside the Practice area (catchment area) and that we are not required to provide you with a home visit. You may on occasion, develop an urgent illness or injury at home that means attending the GP surgery as normal would not be appropriate.

If you require a GP please contact the Practice in the first instance. If we determine you need access to services local to where you live, we may ask you to call NHS 111. In these circumstances, NHS 111 will direct you to the local service that has been established by NHS England for patients such as you. This local service could be a GP Practice near to where you live, the local walk-in or urgent care centre, A&E or minor injuries unit.

This local service will then decide if you can attend for an urgent face to face appointment with a healthcare professional or if a home visit is needed which will be based on your individual circumstances. If this is in the out-of-hours period when GP surgeries are normally closed – between 8.00pm and 8:00am weekdays and during weekends – NHS 111 will direct you to the local out-of-hours provider.

Occasionally following a visit to the Practice you may be referred by your GP to an external service or hospital for treatment. If this is the case you will have a choice of provider either located in your own Borough or here in Wandsworth. Please let your GP know your preference at time of referral.

Please sign below agreeing to the above.

Signature: _____ Date: _____

ARE YOU A CARER?

A Carer is someone who, with or without payment, provides help and support to a partner, child, relative, friend or neighbour who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. The term Carer should not be confused with a care-worker or care assistant, who receives payment for looking after someone.

YES / NO

ELECTRONIC PRESCRIPTION SERVICE (EPS)

Most prescriptions can be sent directly to a Pharmacy, saving you the need to collect them from the Practice and also saving paper. Our onsite Pharmacy (Paydens) works closely with the Putneymead GPs and we can nominate them to receive your prescriptions directly. Paydens can offer a home delivery service for patients who are less mobile.

Where would you like us to send your prescriptions? (Please tick or write below)

Paydens - 266 Upper Richmond Rd, London SW15 6TQ **–** inside Putneymead ☐

Putney Pharmacy - 278 Upper Richmond Rd, SW15 6TQ ☐

Husbands - 124 Upper Richmond Rd, Putney, London, SW15 2SP ☐

Other Pharmacy…….... Postcode…….

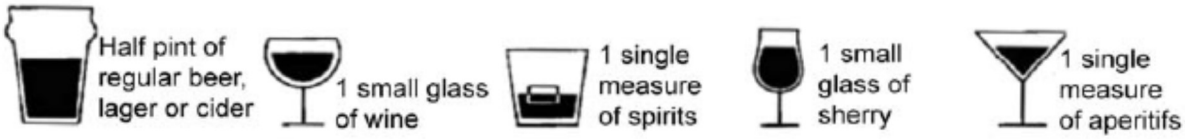
Scripts will be ready after 4pm in

3 FULL WORKING DAYS

Please turn overleaf

ALCOHOL INTAKE

PLEASE ANSWER THE FIRST FOUR QUESTIONS



EACH OF THE ABOVE IS ONE UNIT OF ALCOHOL

EACH OF THESE IS MORE THAN ONE UNIT OF ALCOHOL

How many units of alcohol do you have a week? ☐

PLEASE CIRCLE THEN ADD UP YOUR SCORE BELOW

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	

YOU ARE VERY WELCOME TO MAKE AN APPOINTMENT WITH THE NURSE OR DOCTOR TO DISCUSS YOUR ALCOHOL COSUMPTION AT ANY STAGE; IN TURN WE MAY CONTACT YOU IF THERE ARE ANY CONCERNS.

ADD UP SCORES IN 3 BOXES ABOVE & PUT TOTAL IN HERE

TOTAL AUDIT C ☐

IF YOU HAVE SCORED 5+ IT MAY INDICATE HAZARDOUS OR HARMFUL DRINKING. PLEASE THEN COMPLETE THE MORE DETAILED AUDIT OVERLEAF

IF YOU HAVE SCORED LESS THAN 5 THERE IS NO NEED TO ANSWER THE QUESTIONS OVERLEAF AND YOU MAY HAND YOUR FORM BACK TO A RECEPTION DESK.

ONLY COMPLETE IF SCORE ON PREVIOUS PAGE IS 5 OR MORE

Remaining alcohol questions

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	

ABOVE TOTAL

Total Audit C (FROM PREVIOUS PAGE)

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 higher risk, 20+ possible dependence

TOTAL Score equals
AUDIT C Score (Previous page) +
Score Above

TOTAL

OFFICE USE ONLY:

IF SCORE OVER 15 PLEASE PROVIDE BRIEF INTERVENTION LETTER.

Please turn overleaf

PUTNEYMEAD GROUP

MEDICAL PRACTICE

Application for online access to my medical record

I wish to have access to the following online services (please tick all that apply):

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

1.

2.

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

**Please note that by 31/03/2015 you will be offered basic access to your records (medications, allergies and adverse reactions). Extended access will be rolled out in stages from 01/04/2015*

You do not need to do anything to obtain extended access, you will be able to view additional items e.g. test results, problems, letters when they become enabled

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Please note that this practice is only responsible for the data entered since you registered with us.

It is still your right under DPA 1998 to request any factual amendment, no entry can be removed but your comment will be recorded.

Signature	Date

1. For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method	Photo ID and proof of residence ☐ Photo ID (existing patients) ☐ Vouching ☐ Vouching with information in record ☐
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled	Contractual minimum ☐ Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐		Notes / explanation