Name: …………………………

Date of birth:……………………

Address: ……………………….

…………………………………..

Ethnic origin (please tick all that apply):

White, British Indian

British, other Chinese

Black African Black Caribbean Black British Sri Lankan

European

Other (please state below)

……………………………………………….

First speaking language, Do you need a translator?

……………………………………………….

Height: …………..………………cm/ft Weight…………….…....... kg/stone

Do you smoke? Yes / No

If so, how many? …………..

Are you a Carer? Yes / No

If so, would you like to be referred to the Carers’ Support scheme? Yes / No

Do you have any allergies Yes / No

If so, what are they? ………………………

Patient’s signature…………………………

Date:……………………………………......

**Parent or legal guardian:**

Surname: …………………………………

Forename: ………………………………..

Date of Birth: …../……./………  
Relationship………………………………

Phone No:………………………………..

Next to kin:……………………………….

**Electronic Prescription Service**

We will soon no longer be able to provide printed prescriptions. You will need to nominate a pharmacy for your prescriptions to be sent to electronically.

You can change your nominated pharmacy at any time by either informing us or your new chosen nominated pharmacy.

Name and address of nominated pharmacy: **……………………………………**

**……………………………………**

**……………………………………**

**Taking regular medication? Please provide us with your repeat prescription list, without this requests may take longer**

**Summary Care Record**

The SCR record is a system that is linked up by the NHS Spine, it enables information to be shared between GP practices and emergency services such as Out of Hours, A&E and for in patients in hospital. This helps provide authorised clinicians involved in emergency care with faster secure access to key information about your health.

There are three options:

1. Express consent for medication, allergies & adverse reactions only
2. Express consent for medication, allergies, adverse reactions & additional information
3. Expressed Dissent (Opted Out)

Additional information could also be included, with your consent, this includes:

* Significant medical history, past and present
* Significant procedures, past and present
* Anticipatory care i.e. DNR if in place
* Palliative care information
* Immunisations

Please tick and sign if you have a preference about what information is shared about you:

 Express consent for medication, allergies & adverse reactions only **- 9Ndm**

 Express consent for medication, allergies, adverse reactions & additional information **9Ndn**

Sign ................................

If you would like to opt out from the summary care record, then please ask at reception for an opt out form when you return this registration form.

**Vulnerable patients and carers**

Certain vulnerable patient groups such as those with dementia or with detailed and complex health problems can particularly benefit from additional information in their SCR. If you are a carer for another person and believe that they may benefit from additional information in their SCR, then you can discuss this with them and their GP practice.

**……………………………………………………………………………………………**

**Do you have any communication needs such as hearing or vision problems?**

Hearing  Vision  Learning disability 

Please ask at reception for a communication needs identification form

**FAST Alcohol Screening**

**Half pint of regular beer, larger or cider, 1 small glass of wine, 1 single measure of spirits, 1 small glass of sherry, 1 single measure of aperitifs**

**…and each of these is more than one unit**

**2 Pint of Regular Beer Lager Cider, 3 Pint of Premium Beer Lager Cider, 1.5 Alcopop or can bottle of regular lager, 2 440ml can of premium lager or strong beer, 4 440ml can of super strength lager, 2 glass of wine 175ml 9 bottle of wine**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| **Only answer the following questions if the answer above is Less than monthly (1), Monthly (2), Weekly (3) or Daily/Almost Daily (4). Stop here if the answer is Never (0),** | | | | | | |
| 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 been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 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 |  |

**Scoring:**

A score of 0 on the first question indicates FAST negative

A total of 1 – 2 on the first question then continue with the next three questions.

A total of 3 – 4 on the first question stop screening at first question.

An overall total score of 3 or above is FAST positive.

**SCORE**

**Staff only**

**Please enter score under code - 338u**

**Patient Online Access Form**

**Name:**

**Email address:**

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

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| View your Summary Record |  |

**Application for online access to my medical record**

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

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

|  |  |
| --- | --- |
| Signature: | Date: |

**For practice use only**

|  |  |  |
| --- | --- | --- |
| **ID Verified by (initials)** | **Date:** | **Method**  Photo ID  Vouch for  Vouch with verification |

Online Access for children aged between 11-15 will need to sign the appropriate form for their consent that the parents can gain access to book appointments or request repeat medication