|  |  |  |
| --- | --- | --- |
| **NHS** |  | Family Doctor Services Registration |
| **Patient’s details** | *Please complete in BLOCK CAPITALS and tick as appropriate* |
| [ ]  Mr | [ ]  Mrs | [ ]  Miss | [ ]  Ms | Surname  |
| Date of Birth |  |  |  |  |  |  |  | First names  |
| NHSNo. |  |  |  |  |  |  |  |  |  |  |  Previous surname/s  |
| [ ]  Male | [ ]  Female | Town and country of birth  |
| Home Address  |
|  |
| Postcode  | Telephone number  |

**We will need to trace your previous medical records so please provide us with the following information**

|  |  |
| --- | --- |
| Your previous address in UK | Name of previous doctor while at that address  |
|  | Address of previous doctor |
|  |  |

**If you are from abroad**

|  |  |
| --- | --- |
| Your first UK address where registered with a GP |  |
|  |  |
| If previously resident in UK, date of leaving | Date you first came to live in UK |

**If you are returning from the Armed Forces**

|  |  |
| --- | --- |
| Address before enlisting |  |
|  |  |
| Service or Personnel number | Enlistmentdate |

**If you are registering a child under 5**

|  |  |
| --- | --- |
| [ ]  | I wish the child above to be registered with the doctor named, for Child Health Surveillance |

**If you need your doctor to dispense medicines and appliances \***

|  |  |  |
| --- | --- | --- |
| [ ]  | I live more than 1 mile in a straight line from the nearest chemist | \* Not all doctors are authorized to  dispense medicines |
| [ ]  | I would have serious difficulty in getting them from a chemist |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Signature of Patient | [ ]  | Signature on behalf of patient |  Date |

…………………………………………………………………………………….

|  |
| --- |
| **NHS Organ Donor registration** |
| I would like to join the NHS Organ Register as someone whose organs may be used for transplantation after my death. |
| Please tick as appropriate |
| [ ]  Kidneys |  | [ ]  Heart |  | [ ]  Liver |  | [ ]  Corneas  |  | [ ]  Lungs |  | [ ]  Pancreas | [ ]  Any part of my body |
| **Signature confirming consent to organ donation Date** |
| ……………………………………………………………… |
| *For more information, please ask for the leaflet on joining the NHS Organ Donor Register* |

|  |
| --- |
| **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 Date**  |
| ………………………………………………………………*For more information, please ask for the leaflet on joining the NHS Blood Donor Register**My preferred address for donation is: (only if different from above, e.g. your place of work)*………………………………………………………….. Postcode: ……………………………..  |

# Please note that Clarendon Lodge Medical Practice are involved in ‘GP2GP’

# We would like to draw to your attention, therefore, that if you ever leave and re-register with a new doctor, your medical notes will be sent electronically to your new GP Practice.

|  |  |  |
| --- | --- | --- |
| **Identity verified by****(initials)****RECEP TO CHECK:-** | **Date** | **Photo ID Proof of Residence** **Driving Licence 🞏 Bank Statement 🞏****Passport 🞏 Utility Bill 🞏****ID Card 🞏 Council Tax 🞏****RECEP PLEASE TICK ONE OF EACH** |

**NEW PATIENT HEALTH CHECK**

# NEW PATIENT APPOINTMENT WITH OUR PRACTICE NURSE/HEALTH CARE ASSISTANT

Date of New Patient Check appointment: ......………………… Time: ................

Welcome to Clarendon Lodge Medical Practice. We would be grateful if a confidential questionnaire could be completed for every new patient registering with the practice.

Once the completed questionnaire is returned, together with the attached ‘family doctor services registration form’, we will be able to proceed with your registration.

We offer all patients, registering with the Practice, a “new patient consultation”. We strongly recommend that you make an appointment because the information gained at this meeting and through the questionnaire, helps us to provide you with the best care and attention possible.

Thank you for your time.

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **First Name/s** |  |
| **Title** |  | **Known as** |  |
| **Date of birth** |  | **Occupation** |  |
| **Ethnic Group** |  | **First Language** |  |
| **Next of Kin** |
| **Contact telephone number for next of kin** |
| **Do you have a carer**? | [ ]  yes  | [ ]  no | If yes please give name and contact telephone number………………………………………………………… |

|  |
| --- |
| **Are you a carer?** [ ]  yes [ ]  no If yes, please give name, relationship to you (with their permission) (not as your employment) and contact number. Is  this person a patient at this practice? Y?N **……………………………………………………………………………………………………………………………** **PERSONAL MEDICAL HISTORY** |
| **1.** | **Significant Illnesses/Conditions** (please tick relevant boxes) |
| Insulin treated diabetes | [ ]  | Tablet treated diabetes | [ ]  | Diet controlled diabetes | [ ]  |
| High blood pressure | [ ]  | Heart disease | [ ]  | Asthma | [ ]  |
| Cancer | [ ]  | Epilepsy | [ ]  | Thyroid problems | [ ]  |
| Stroke | [ ]  | Other chest problems | [ ]  | Other ………………………... |
|  |
| **2.** | **Operation/s** | **Date/s** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| **3.** | **Other Admission/s to hospital** | **Date/s** |
|  |  |  |
|  |  |  |

**FAMILY MEDICAL HISTORY**

(please tick relevant boxes)

|  |  |  |
| --- | --- | --- |
| High Cholesterol of 7.5 or greater [ ]  | If so, which member of the family? |  |
| Heart Attack [ ]  | If so, which member of your family? How old were they when they had the heart attack? |  |
| Heart disease [ ]  | Stroke [ ]  | Cancer [ ]  | Diabetes [ ]  | Hypertension [ ]  | Asthma [ ]  |
| Other [ ]  (please specify) |

**DRUGS AND MEDICINES**

(please tick relevant boxes)

|  |  |  |
| --- | --- | --- |
| Are you being prescribed medication on a repeat basis | [ ]  yes  | [ ]  no |
| Are you allergic to any medications? [ ]  yes [ ]  no If yes, please state …………………………......…………………………………………………………………………………………………………….. |

**DISABILITY INFORMATION**

(please tick relevant boxes)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Partially sighted  | [ ]  | Blind | [ ]  | Hearing impaired | [ ]  | Deaf | [ ]  | Speech Defect | [ ]  |
| Dyslexia | [ ]  | Learning disability | [ ]  | Mental Illness | [ ]  | Mobility problem (please explain) [ ]  |

**LIFESTYLE**

(please tick relevant boxes)

|  |  |  |
| --- | --- | --- |
| Do you smoke? | yes[ ]  no [ ]  | If yes, number per day …………….. |
| If ‘no’ are you an ex-smoker? | yes [ ]  no [ ]  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 units of alcohol do you have on a typical day when you are 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/almost daily[ ]  |
| Scoring System | 0 | 1 | 2 | 3 | 4 |
| A total of 5+ indicates increasing or higher risk drinking. If you score 5+ we recommend that you make an appointment with one of our nursing team. | **Overall score =** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Exercise** | Very active | [ ]  | Moderate | [ ]  | Gentle | [ ]  | Inactive | [ ]  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Diet** | Good [ ]  | Moderate | [ ]  | Poor [ ]  | Vegetarian [ ]  | Vegan [ ]  |

**ABOUT YOU**

(please tick relevant boxes)

|  |  |
| --- | --- |
| Height …………………………….. | Weight ………………………………. |

|  |
| --- |
| Non-drug allergies (ie nuts, insect bites, pollen) ………………………………. |
| Mild | [ ]  | Moderate | [ ]  | Severe | [ ]  | Very Severe | [ ]  |

Do you take Aspirin regularly, which you buy over the counter? Yes [ ]  No [ ]

Have you had any of the following immunizations? Please give the date (year will suffice) and stage ie booster etc.

|  |  |  |  |
| --- | --- | --- | --- |
| Tetanus | [ ]  |  date ……… | stage ……………. |
| Combined Diphtheria/Tetanus | [ ]  |  date ……… | stage ……………. |
| Polio |  |  date ……… | stage ……………. |
| Flu [ ]  | date ………. | Pneumovax [ ]  |  date ………. |

**FOR WOMEN**

Form of contraception used:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| The Pill | [ ]  | Coil (IUD) | [ ]  | Condom | [ ]  | Diaphragm (Cap) | [ ]  |

**Ethnicity Name : ………………. DOB …………..**

|  |
| --- |
| **White** |
| British |  | Irish |  |  |
| Other |  |  |
| **Mixed** |
| White/Black Caribbean |  | White/Black African |  |  |
| White/Asian |  | Other mixed background |  |  |
| **Asian** |  |  |  |  |
| Indian |  | Pakistani |  |  |
| Bangladeshi |  | Other Asian background |  |  |
| **Black or Black British** |
| Caribbean |  | African |  |  |
| Other |  |  |  |  |
| **Chinese** |  |  |
| **Other** |
| Other |  | Unknown |  |  |

**Religious Beliefs**

|  |  |  |  |
| --- | --- | --- | --- |
| Baha’i |  | Buddhist |  |
| Christian |  | Hindu |  |
| Jain |  | Jewish |  |
| Muslim |  | None |  |
| Pagan |  | Sikh |  |
| Zoroastrian |  | Unknown |  |
| Other |  |  |  |

**Sexual Identity Name : ………………. DOB …………..**

|  |  |  |  |
| --- | --- | --- | --- |
| Heterosexual/Straight |  | Gay or Lesbian |  |
| Bisexual |  | Other |  |
| Unknown |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | IF YOU DO NOT WANT A SUMMARY CARE RECORD PLEASE COMPLETE AND SIGN THIS FORM.IF YOU DO WANT A SUMMARY CARE RECORD, PLEASE DISREGARD THIS FORM. |  |

What is the NHS Summary Care Record?

**The new NHS Summary Care Record is being introduced to help deliver better and safer care and give you more choice about who you share your healthcare with.**

**The Summary Care Record will contain basic information about any** allergies you may have, unexpected reactions to medications and any prescriptions you have recently received.

**The intention is to help clinicians in Accident and Emergency Departments and ‘Out of Hours’ health services to give you safe, timely and effective treatment.**

**Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access in unnecessary.**

Children under the age of 16

**Patients under 16 years will not receive this letter, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise.** If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.

**You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you decided to proceed, but at any time in the future you, or a child you are responsible for, change your mind and choose not to have a Summary Care Record, all you need do is write to your Surgery informing them of your decision to “Opt-out”. If you have already told your Surgery that you wish to “Opt-out” and you wish this to remain in place you need take no further action.**

PLEASE ONLY COMPLETE AND SIGN THE BOTTOM SECTION IF YOU DO NOT WANT A SUMMARY CARE RECORD. Otherwise disregard this form.

Patient Name………………………………………………….

NHS Number (***if known***) ………………………….. Date of Birth ………………………….

Signed by Patient ………………………………………….. Date ……………………………….

**Electronic Prescription Service**

If you have nominated a Pharmacy previously using this system and then recently joined our Practice – please ensure that your nominated Pharmacy is up to date – either with the Practice or your new Pharmacy of your choice.

For more information on the Electronic Prescription Service visit – [www.connectingforhealth.nhs.uk/eps](http://www.connectingforhealth.nhs.uk/eps)

If you wish to use the Electronic Prescription Service – please ask at your local Pharmacy or at Reception at Clarendon Lodge.

Please complete the Nomination form below to enable us to update your records if you wish to use this service .

**Nomination Form for Electronic Prescriptions**

**Name …………………………. Date of Birth……………………**

**Address ………………………………………………………………**

**Nominated Pharmacy/ Name of pharmacy**

**……………………………………………………………………..**

**Address of Pharmacy :**

**……………………………………………………………………….**

**Post Code of Pharmacy ………………………………….**

**Signed: …………………………… Date …………………………...**

**For Practice use only.**

**Updated on Vision …………………………………………….**

**Date ………………………. Staff initials ……………………….**

|  |  |
| --- | --- |
|  |  |
| **Clarendon Lodge Medical Practice** |  |

# Application for online access to my medical record

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

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my Summary of Medical Record
 | 🞏 |
| Accessing my Detailed Coded Records – *Please ask at reception for full details how to register* |  |

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
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. 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

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| **Identity verified by****(initials)****RECEP TO CHECK:-** | **Date** | **Photo ID Proof of Residence** **Driving Licence 🞏 Bank Statement 🞏****Passport 🞏 Utility Bill 🞏****ID Card 🞏 Council Tax 🞏****RECEP PLEASE TICK ONE OF EACH** |
| Authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access enabled Prospective 🞏 Retrospective 🞏 All 🞏Limited parts 🞏 Contractual minimum 🞏  | Notes / explanation |

**Clarendon Lodge Medical Practice**

***Online Medical Record Access –Detailed Coded Records***

This practice also offers you the opportunity to use the internet to securely view your electronic medical record held by the surgery. There are also links to information leaflets about diseases, tests, investigations, support groups and medications and links to websites such as NHS Choices and patient.co.uk where you can find more information to help you understand about what you read in your record.

The system allows you to view the following areas of your medical record:

* A summary that gives you the most important and recent entries in your health record
* Allergies
* Patient Information Leaflets linked from the diagnoses in the medical record section
* Results showing recent investigations such as blood results, blood pressures and x-rays
* Some vaccinations
* Medications
* Consultations

*NB The service is currently only available for patient aged 16 and over. We hope to extend this facility to the under 16s at a later date.*

**Should you wish to access your Detailed Coded Records - Please ask at Reception for further information and application form.**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Accessible Information Standard**

As part of the accessible information standard we wish to make sure that patients and service users, and their carers and parents, can access and understand the information they are given by Clarendon Lodge Medical Practice

If you have any information or communication needs - which relate to a disability, impairment or sensory loss. We can provide for instance letters in large print or Braille, or if you require an interpreter/ translator for consultations with the Doctor or Nurse. **Please ask Reception for an information form.**