WATERCRESS MEDICAL

New Patient Registration Form

(for all new patients aged 16 or over)

Please complete **all** sections and return this confidential questionnaire to Reception with a form of photographic ID (ie driving licence/passport) and proof of address

Complete in **BLOCK CAPITALS** and tick the boxes as appropriate

Complete a separate form for each family member to be registered

<table>
<tr><td colspan="2">Personal details:</td></tr>
<tr><td>Title: Dr / Mr / Mrs / Miss / Mx / Other</td><td></td></tr>
<tr><td>Full Name:</td><td>Previous Surname
(if different):</td></tr>
<tr><td rowspan="4">Address and Postcode:</td><td>Telephone Number:</td></tr>
<tr><td>Mobile Number:</td></tr>
<tr><td>Work Number:</td></tr>
<tr><td>E-mail:</td></tr>
<tr><td>NHS No:</td><td>Date of Birth:</td></tr>
<tr><td>Gender (at birth):</td><td rowspan="2">Town & Country of Birth:</td></tr>
<tr><td>Marital Status:</td></tr>
<tr><td colspan="2">Occupation:</td></tr>
<tr><td colspan="2">If applicable, date you first came to live in Britain:</td></tr>
<tr><td colspan="2">Previous Home Address:</td></tr>
<tr><td>Previous Doctor’s Practice & Address:</td><td>Reason for leaving previous Practice:</td></tr>
</table>

Armed Forces Veteran - complete if you have served in the British Armed Services:			
Please delete as appropriate: **Army / Naval / Air**	**Your Service or Personnel No:**	**Your Enlistment Date:**	**Date of leaving Armed Forces:**

Your Religion: Please tick as appropriate √					
C of E	Catholic	Other Christian	Buddhist	Hindu	Muslim
Sikh	Jewish	Jehovah's Witness	Other Religion	Declined to comment	
Your Ethnic Origin: Please tick one as appropriate √					
White British	White Irish	White Other	African	Asian	Bangladeshi
Caribbean	Chinese	Indian	Other Mixed background	Other Asian background	Other
Pakistani	Declined to comment				
Your Main or First language - Spoken / Understood:					
Do you require the help of a Translator / Interpreter?					
Your Weight:	Stones / lbs:		kg:		
Your Height:	ft / inches:		m / cm:		
Smoking and Exercise: Please tick as appropriate √					
Are you currently a smoker?	Yes / No	**Have you ever been a smoker?**		Yes / No	
If Yes, what type of smoker are you?	Cigarettes	Cigars	Vaping	Other	
How many do you smoke per day?		**If No, when did you stop?** (enter date)			
I have never smoked?					
If you are a smoker and want to stop, would you like to be contacted about our local smoking cessation services? **Yes / No**					
How often do you exercise?	**No. times per week:**	**Type(s) of exercise:**			

Your Medical History: If you suffer from any of the following conditions, please tick and if you cannot remember exact diagnosis dates just enter the year:					
	√	**Date**		√	**Date**
Coronary/Ischaemic Heart Disease			**Epilepsy**		
Heart Attack (age if known)			**Hypothyroldism**		
Angina			**Cancer**		
Stroke (age if known)			**Depression**		
Hypertension (on tablets for high blood pressure)			**Kidney Disease**		
Atrial Fibrillation			**High Cholesterol**		
Diabetes			**Mental illness / Psychosis**		
Asthma					
Other (please give details)					
You will be contacted, after registration, and offered an appointment with the appropriate clinician for the condition you have indicated above.					

Your medication:	
Are you currently taking medication, if Yes, please list below:	
If these are prescription only medicines, please bring your last repeat script or the boxes with labels so that we may continue to issue your medication. In certain circumstances, your doctor may wish to see you before prescribing further medication.	
Specific Needs	
Please state any Sensory Impairment, Speech, Hearing, Sight:	
Please state any physical disabilities:	
Please state any mental disabilities:	
Please state any requirements you may need to access the Practice premises:	
Do you have any special communication needs? Sign Language, Large print, Other	

Your Immunisations (please tick all that apply)					
Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
Whooping Cough	Triple vaccine: (Diphtheria, Tetanus & Pertussis) – 3 doses				
(If applicable) When was your last smear?					
Date:		What was the result of the smear:			
Method of contraception (if used):		Do you wish to see a clinician in this practice for contraceptive services? **Yes / No**			

Family Medical History: If any members of your close family suffer from any of the following conditions, please tick				
	Mother	**Father**	**Brothers**	**Sisters**
Coronary/Ischaemic Heart Disease				
Heart Attack (age if known)				
Angina				
Stroke (age if known)				
Hypertension (on tablets for high blood pressure)				
Diabetes				
Cancer (specify type)				
Asthma				
Any other important family illness				

Emergency Contact Information In an emergency there may be a need for us to speak to a family member or your next of kin. If you consent to this, please supply the following information:		
Name & Address:	Contact Information:	Relationship to you
Next of Kin: Yes / No	Can discuss medical record: Yes / No	
If you <u>have</u> a Carer, please provide their contact details and sign if you wish us to disclose information about your health to them:		
Carers Name:	Address:	Telephone Number:
Patient signature:		**Date:**
If you <u>are</u> a Carer please complete Appendix B: Carers Identification & Referral Form		
Do you have a Living Will (a statement explaining what medical treatment you would not want in the future)	Yes / No	*If 'Yes' please bring a written copy to the Practice so that it can be scanned onto your medical record.*
Have you nominated someone to speak on your behalf (eg a person who has Power of Attorney)	Yes / No	If 'Yes' please state their name, & telephone number.

NHS App

The NHS App lets you order repeat prescriptions and book some appointments as well as providing access to a range of other healthcare services. The App is for people aged 13 and over who are registered with a connected GP surgery and is free to download from the App Store and Google Play.

If you do not have a smartphone or tablet, please speak to one of our Patient Advisors at reception and ask for Patient Access details – you will need to provide photographic id.

Data Extraction Consent

I do / I do not (*please delete as appropriate)* consent to electronic information that identifies me to be shared outside of my GP practice eg with other health organisations such as hospital, out of hours service, A&E (other than where necessary by law eg if there is a public health emergency). Please ensure you have read the Practice Privacy Policy (available on our website) and completed, if applicable, the Data Sharing leaflet Appendix C, so that you fully understand the implications if you choose to **not consent** to information sharing.

Signed: …… Date: ……..

Using your data to contact you – consent preferences for text messages

In line with the General Data Protection Regulations (GDPR 2018) we must seek consent to send you information via text.
We use electronic messaging for appointment confirmation, some medical results, invitations to health clinics such as asthma, hypertension and medication reviews or to let you know there are prescriptions or paperwork to be collected.
We might also send you invites to health campaigns, such as Flu if you are eligible and to gather information about your smoking status and other health information gathering.

These messages are sent via a secure NHS service. We will never send urgent communications via these methods or sensitive clinical data without your permission.

Where you have provided your contact information, please let us know, below, if you consent for us to contact you:

Via Text *(delete as appropriate)*	**Yes,** I would like to **OPT-IN** for text messages **No,** I would like to **OPT-OUT** for text messages and I am aware this includes text messages for appointments etc.

Please ensure that, where you have provided us with your contact details and have opted in for messaging that you keep us informed of your up to date contact details to avoid any breach of your data.

Please be aware that when we send sensitive information to you electronically, it is your responsibility to ensure that this information is kept securely and cannot be accessed by anyone other than yourself unless at your expressed wish.

MANSFIELD PARK SURGERY Patient Participation Group
The Practice is committed to improving the services it provides for patients, so it is vital that we hear about patients' experiences and views for making our service better. The Group has an active Committee and supports the practice in various ways. Would you be willing to join and be contacted by email by the Chairman for occasional surveys or opinions? **Yes / No** *(please delete as appropriate)*

Patient Declaration ***(****please tick boxes and sign)*
I confirm I have read and agree to the Practice Privacy Policy ☐ **I confirm the information provided is correct** ☐
Signed:…… Date:…… **PRINT NAME:……**

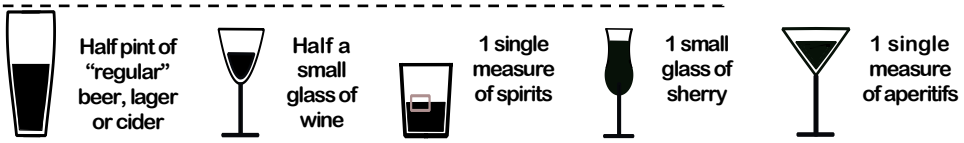
Thank you for completing this questionnaire and the Alcohol Consumption form overleaf.
Please return it all to Reception to complete your registration.

For more information about the services we offer please visit our website:
www.watercressmedical.co.uk

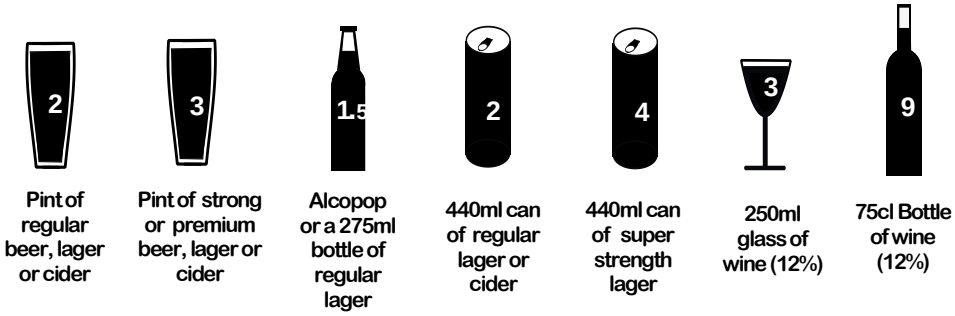
Office Use Only
Type of ID provided:
Checked by: **Date:**

APPENDIX A - ALCOHOL CONSUMPTION QUESTIONNAIRE

This is one unit of alcohol…



…and each of these is more than one unit



ACCORDING TO THIS CHART HOW MANY UNITS DO YOU DRINK PER WEEK?

_____

AUDIT	**Scoring system** *(choose appropriate option (ie 0-4)*					**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?	0 -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	
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	

APPENDIX B - Carers Identification and Referral Form

Do you look after someone who is ill, frail, or who suffers with disabilities or mental health issues.

If so, you are a carer and we would like to support you.

Please complete this form and hand it in to reception.

If you give consent (by signing this form) we will pass your details to the Princess Trust, which is a countrywide organisation providing relevant information and advice, local support services, and newsletters for carers.

Your details:

Name	
Date of Birth	
Address	
Post Code	
Telephone Number	
Any other relevant information	

Details of the person you look after:

Name	
Date of Birth	
Address (if different from above)	
Post Code	
Telephone Number	
GP details	

Please pass my details to the Princess Trust

Signed :…… **Date**:……

APPENDIX C - Data Sharing

Please complete the information below with your choices on sharing your data and hand to Reception.

Name:…… Date of Birth:……

Address:……

……

National Data: Your data may sometimes be used for research and planning to improve healthcare services. For more information, or if you do not wish for your data to be used in this way, please visit www.nhs.uk/your-nhs-data-matters/ **The Practice is no longer able to opt out for you.**

Summary Care Record:

I do not wish to have a Summary Care Record ☐

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication)

Care & Health Information Exchange (formerly Hampshire Healthcare record):

I do not wish to have a Care & Health Information Exchange Record ☐

Secondary Uses:

I would like to opt-out of **all** 'secondary' uses of my GP Record ☐

EMIS Web:

I would like to opt-out of EMIS Web data streaming, please disable this from my GP Record ☐

Signed:…… Date:……