Royal Crescent and Preston Road Practice

New Patient Registration

This form must be filled out by all Patients registering with our Practice.
Please return this form with your GMS1 form or Medical Card to Reception, so we can complete your registration.
It may be some time before we receive your medical records, so the following information will be helpful to us in assessing your health care needs.

Personal Information					
Title:		First Name:		Surname:	
Date of Birth:				Age:	
Address:					
Post Code:		Place of birth:			
Contact Telephone Numbers & Email					
Home:		Mobile			
Work:		Email			

Occupation (if retired please state previous occupation)

Height:		Weight:	
Smoking Status (Please tick)			
Never Smoked		Ex-Smoker		When did you give up?	
Current Smoker		How many do you smoke per day?	
In the interest of your health and wellbeing, your Doctor advises you to give up smoking. **Would you like a referral to our Smoke Stop Service? We can offer free support and can provide various aids to help you give up on prescription.**		Yes ☐ No ☐	

Do you have any Significant Medical Problems (e.g. Asthma, Diabetes, Heart Disease, Pulmonary Disease)	Yes ☐ No ☐
Are you prescribed any regular medication/having regular injections?	Yes ☐ No ☐
If **YES** Please give us the name of your nominated Pharmacy	

Newly registered patients taking regularly prescribed medication or having regular injections will need to see the Nurse Practitioner or Doctor before you are due your first prescription or injection

Do you have any communication or information needs relating to a disability, impairment or sensory loss? If yes, what needs do you have and how can we help you with this. (*please state below*)	Yes ☐ No ☐
Do you have any family history of illnesses (i.e. Diabetes, Cancer, Heart Disease, Stroke) *(Please state below)*	Yes ☐ No ☐

Next of Kin details	
Name:	Relationship to you:
Address	
	Tel Number:
Are you a carer, do you care for someone?	
Name of person you care for:	Relationship to you:
Address	
	Tel Number:

Alcohol Intake - Please circle the relevant answer

Questions	Scoring system					Your Score
	0	1	2	3	4	
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 standard alcoholic drinks 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 or almost daily	
				Total Score		

If you have scored <u>5 or more</u> on the above questions, please could you now complete the remaining questions

Questions	Scoring system					Your Score
	0	1	2	3	4	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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 /friend /doctor/ health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
				Total Score		
					Total Score for both sets of Questions	

If you have scored 8 or more on the previous questions, please could you now complete this questionnaire.

Over the last **2 weeks**, how often have you been bothered by any of the following problems?
(use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns:				
TOTAL:				

(use √ to indicate your answer)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	
	Somewhat difficult	
	Very difficult	
	Extremely difficult	

Ethnic Group	Tick here		Tick here
A: White		**D: Black or Black British**	
• British		• Caribbean	
• Irish		• African	
• Any other White background (please state)		• Any other Black background (please state)	
B: Mixed		**E: Chinese or other ethnic group**	
• White and Black Caribbean		• Chinese	
• White and Black African		• Any other (please state)	
• White and Asian		**Not stated / Declined:** Declined: patient chooses not to supply this information	
• Any other mixed background (please state)			
C: Asian or Asian British			
• Indian			
• Pakistani			
• Bangladeshi			
• Any other Asian background (please state)			

What is your main spoken language (please tick)					
Akan (Ashanti)		Hakka		Serbian	
Albanian		Hausa		Shona	
Amharic		Hebrew		Sinhala	
Arabic		Hindi		Somali	
Bengali		Igbo (Ibo)		Spanish	
Brawa		Italian		Swahili	
British Sign Language		Japanese		Swedish	
Cantonese		Korean		Sylheti	
Croatian		Kurdish		Tagalog (Filipino)	
Czech		Kutchi		Tamil	
Dutch		Lingala		Thai	
English		Lithuanian		Tigrinya	
Ethiopian		Luganda		Turkish	
Farsi (Persian)		Makaton Sign Language		Ukrainian	
Finnish		Malayalam		Urdu	
Flemish		Mandarin		Vietnamese	
French		Norwegian		Welsh	
French Creole		Pashto (Pushtoo)		Yoruba	
Gaelic		Patois		Other (Please write in line below	
German		Polish			
Greek		Portuguese		Patient Refused	
Gujerati		Punjabi			
		Russian			

In order to protect the NHS from patient registration fraud the Department of Health require that we ask all new patients over the age of 16 years to provide 2 documents of identification when registering. For those patients under that age of 16 years a copy of their birth certificate will be sufficient.

A combination of the following can be accepted as identification. One item of photo ID, along with one document containing your address (must be less than 3 months old)

Birth certificate		National Insurance Number Card	
Marriage Certificate		Payslip	
Medical Card		Letter from Benefit Agency/Benefit Book	
Driving Licence		Signing on Card	
Passport		Papers from The Home Office	
Local authority Rent Card		P45	
Paid Utility Bills		Other – Please specify	
Bank / Building Society Card/Statement			

Once you have returned the forms to us along with 2 identification documents we will be able to complete your registration with the Practice and your medical records will be requested from your previous GP Surgery. Please allow 48 hours for us to process your registration. You will then receive a New Patient Information Pack

Date form completed: _____

Office use only:

Welcome pack given out to every patient over the age of 15		Information coded on computer	
If on current medication or has regular injections make an appointment for NP or GP		Alcohol protocol followed	
If over 45 – make an appointment for HCA for BP check		Organ donor?	
Smoking advice information given to patient if needed		ID Seen:	
Name of the receptionist that took the Registration forms			