CONFIDENTIAL (WHEN COMPLETE)

GLENLYN Medical Group

NEW PATIENT REGISTRATION FORM

People over the age of 13 years old

Welcome to Glenlyn Medical Centre. Please complete the following forms. We pride ourselves on offering a high standard of care and this information is extremely valuable in achieving this.

An administrator will be happy to assist you with any queries you may have. Please bring the completed form to Reception together with your identification documents.

IDENTIFICATION

A combination of any 2 the following documents ONLY can be accepted as identification. You must produce one item of photo ID and one item containing your address (dated within last 3 months)

Bank/building society cards/statements	☐	National Insurance number card	☐
Birth certificate	☐	P45	☐
Driving licence	☐	Paid utility bills	☐
Letter-Benefits Agency/benefit book/signing on card	☐	Papers from the Home Office	☐
Local authority rent card	☐	Passport	☐
Marriage certificate	☐	Payslip	☐
Medical card	☐		

For office use only:

Name confirmation Which document was seen?		**Date of document:**	
Address confirmation Which document seen?		**Date of document:**	
Staff member (write clearly)		**Today's date:**	

ABOUT YOU

Surname:		**Forename(s)**:	
Gender:		**DOB**:	
Address:			
Post code:			
Home Phone:		**Work Phone:**	

TALKING TO YOU – PERSONALLY

It's important to you and to us that we maintain the confidentiality of your medical information and so our practice policy is to only take personal email addresses and mobile phone numbers for people aged 13 years and older. This policy takes account of changes in data protection legislation introduced in 2018.

If you are 13 or over and have a personal email address and / or mobile phone number, we'd like you to tell us it here.

If you are a parent or guardian of a person age 13 to 16, we are unable to accept your email address or mobile number for your child. **If you have concerns about this, please ask to speak to a Manager.**

Mobile Phone Number:

Email Address:

If you would like this form in Large Print or Easy Read, or require assistance because you use British Sign Language, lip-reading or have other communication needs, please let us know.

COLLECTING INFORMATION ABOUT ETHNIC GROUPS

Under the terms of the NHS Contract, the Practice is required to ask all new patients to describe their own ethnic group. This list will allow most people to identify themselves, but if you feel the categories do not describe your ethnic group, please tick 'any other group' and add details of how you would describe yourself (e.g. 'Cornish').

The reasons given by the NHS for collecting this data are that 'information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.'

If you choose not to complete the question we will assume that you have exercised your right not to divulge your ethnicity.

Please tick:

☐ Asian or Asian British – Indian	☐ Black or Black British – African	☐ White – British
☐ Asian or Asian British – Pakistani	☐ Black or Black British – Caribbean	☐ White – Irish
☐ Asian/Asian British – Bangladeshi	☐ Black or Black British – any other Black background	☐ White – any other White background
☐ Asian/Asian British – any other Asian background	☐ Mixed – White and Black African	☐ Mixed – any other mixed background
☐ Mixed – White and Asian	☐ Mixed – White and Black Caribbean	☐ Chinese

☐ Any other ethnic group _____ Language(s) Spoken _____

COLLECTING INFORMATION ABOUT SERVICE FAMILIES & VETERANS

Glenlyn Medical Centre recognises its responsibilities to Veterans and the families of Serving Armed Forces Personnel.

Are you a Veteran? ☐ No ☐ Yes If you answered YES, please ask for a Veterans Registration Form

Please let us know if you are a member of a Service Family. This will allow us to inform other healthcare providers so that you are not disadvantaged by having to move locations with your partner because of the needs of the Service.

Are you a member of a Service Family? ☐ No ☐ Yes

Are you on a waiting list in another place? ☐ No ☐ Yes

Which waiting list: _____ Which Hospital/Referral Place: _____

CARERS

Are you a carer? ☐ No ☐ Yes If you answered YES, please ask for a Carers' Registration Form

(*Do you look after someone who is dependent on you some, or all of the time?*)

EQUALITY STATEMENT

Under the Equality Act 2010, it is against the law for an organisation to discriminate against anyone on the grounds of colour, age, sex, race / nationality - including citizenship - ethnic or national origins, marital status, civil partnership, disability, sexual orientation, any religion, or religious or philosophical belief.

Glenlyn Medical Group is committed to ensuring that the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

YOUR PERSONAL CIRCUMSTANCES:

Do you have significant mobility issues?		**Yes** ☐	**No** ☐
Housebound	☐	Wheelchair user	☐
Very poor mobility	☐		

Are you blind/partially sighted?	**Yes** ☐	**No** ☐
Do you have significant problems with your hearing?	**Yes** ☐	**No** ☐

Have you set up a lasting Power of Attorney for Health & Welfare? ***If so, please bring a copy into the practice with contact details for those who will assume responsibility for you.***	**Yes** ☐	**No** ☐
If so, please give details of those who will assume responsibility for you		

Have you made an advance directive/decision in place about any future care you do not wish to receive?	**Yes** ☐	**No** ☐
If so, are you satisfied that your wishes remain unchanged? ***Please bring a copy into the practice.***	**Yes** ☐	**No** ☐
Have you made a 'Do Not Attempt Resuscitation' order? ('Lilac Form') ***Please bring a copy into the practice.***	**Yes** ☐	**No** ☐
If so, are you satisfied that your wishes remain unchanged?	**Yes** ☐	**No** ☐

MAKING INFORMATION ACCESSIBLE

If you would like us to record your communication needs on your medical record, please indicate below:

☐ Large Print ☐ British Sign Language ☐ Deaf or hard of hearing

☐ Easy Read ☐ Lip reading ☐ Other _____

CONSENT FOR SOMEONE ELSE TO ACT ON YOUR BEHALF

We are unable to discuss any aspect of your care or give your prescriptions to anyone other than you unless we have your express permission. If you would like to give consent for a family member, friend or carer to act on your behalf please complete the following:

I give consent to the following person / people:

Name(s):	
Relationship to you:	

To:

☐ Collect prescriptions on my behalf

☐ Discuss my health and care with practice staff

Please sign and date the box below:

Signed (Patient)		Date	

APPLICATION FOR ACCESS TO ONLINE SERVICES

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

Booking appointments	☐	Requesting repeat prescriptions	☐	Accessing my medical record	☐

If you have ticked 'Accessing my medical record' please read the following statements and tick to confirm your agreement:

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	☐
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signed: ☐	Date: ☐

Please ask for a copy of the Patient Online booklet. Instructions for creating your account will be sent to the email address you gave on page 1

CONSENT FOR TEXT AND EMAIL COMMUNICATION

At Glenlyn Medical Centre, we use email and texts to keep you informed about your care and about the practice.

If you have provided a mobile phone number you will be automatically enrolled for text messages about your direct care such as appointment reminders, test results, annual reviews and vaccination invitations.

If you **DO NOT** want to receive text messages about your direct care, please tick this box here ☐
Please be aware that if you opt-out, you will not receive appointment reminders

If you would like to receive <u>text messages</u> with information about the surgery, such as newsletters or alerts to service changes/disruptions such as planned and unplanned closures of either surgery, please tick the relevant boxes below

If you **DO** want to receive notification of our latest newsletter via text ☐

If you **DO** want to be alerted to service changes/disruptions via text ☐

If you would like to receive <u>emails</u> with information about the surgery, such as newsletters or alerts to planned and unplanned closures of either surgery, please tick the relevant boxes below

If you **DO** want to receive our latest newsletter via email ☐

If you **DO** want to be alerted to surgery closures via email ☐

You may <u>opt out</u> of email and text messaging services at any time – please inform the Practice Manager.

SUMMARY CARE RECORD

An electronic Summary Care Record is automatically created for you when you register. It contains brief health information such as your medications and allergies and can be viewed by clinicians who are treating you in other settings in England, such as A&E, Ambulance Services, other GP surgeries and out of hours services.

If you **DO NOT** want to share your information using the Summary Care Record, please tick this box ☐

YOUR HEALTH STATUS

Height, Weight and Blood Pressure: please ask for a token for the automated blood pressure machine when you bring your forms to the practice and hand the slip to the receptionist with this form.

Smoking status – please tick the appropriate box

☐ Never smoked ☐ Ex-smoker - date stopped _____ ☐ Current smoker - ave/ day _____

For smokers		
Would you like to be referred to the Quit 51 smoking cessation clinic at Glenlyn?	Yes ☐	No ☐

ALLERGIES / INTOLERANCES

Please list any drugs, food or other substances to which you are allergic (i.e. you develop a rash / swelling / anaphylactic shock) or drugs to which you are intolerant (i.e. side effects such as diarrhoea or nausea).

_____ Allergy / intolerance (please circle)

_____ Allergy / intolerance (please circle)

_____ Allergy / intolerance (please circle)

_____ Allergy / intolerance (please circle)

MEDICATIONS

Please provide a list of any repeat medications you are taking:

You will need to see a GP before we can issue any medications that were on repeat at your previous practice.

1.

2.

3.

4.

5.

6.

PRESCRIPTIONS

Glenlyn Medical Centre is an **electronic prescribing practice** and we are phasing out paper prescriptions where possible. Please nominate the pharmacy where you would like to collect your prescriptions and we will send them there electronically. You can find a list of local pharmacies on the NHS Choices website at www.nhs.uk.

I would like to nominate: _____ Pharmacy, _____ Branch _____

FAMILY HISTORY – please indicate if either of your parents, a sibling or a child has been affected by:

Heart attack / Angina	☐ Under 60yrs ☐ 60 yrs+	DVT or pulmonary embolism	☐
Stroke	☐	Asthma	☐
High cholesterol	☐	Diabetes	☐
Hip fracture (parent)	☐	Cancer - please indicate which type and approximate age of affected relative:	☐

CONFIDENTIAL (WHEN COMPLETE)

ALCOHOL SCREENING (not required for patients aged 13-15)

The set of questions on the next page give you and us an indication as to whether you are drinking more than is healthy.

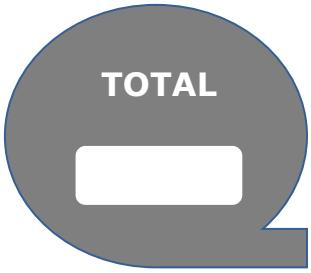
	Scoring system					
Part 1	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total for Part 1:	

If your score is **5** or more, please also complete **part 2** below.

Part 2	**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	

Add up your scores from both Alcohol screening parts 1 and 2 then write the total in the 'TOTAL' box oppostite.

If you would like to talk to a nurse about your drinking, please tick here and we will be pleased to make contact with you. ☐



HEALTH QUESTIONNAIRE

If you have been registered with an NHS GP in England previously, we should receive your medical records electronically – please skip the questionnaire and sign the form at the bottom of page 8.

Complete this health questionnaire if this is the first time you have registered with an NHS GP in England.

Cancer

Type:		Year (approx.)		
Are you receiving treatment**?**			**Yes** ☐	**No** ☐

Heart or Circulatory Problems

High blood pressure	☐	Peripheral vascular disease	☐
Aortic aneurysm (AAA)	☐	Angina/heart attack	☐
Blood clots (DVT/PE)	☐	Stroke/TIA (mini-stroke)	☐
Atrial fibrillation (AF)	☐	Do you have a pacemaker/implanted defibrillator?	☐

Lung or Respiratory Problems

Asthma	☐	COPD/Emphysema	☐
Tuberculosis	☐		☐

Gastro-Intestinal Problems (Stomach & Gut)

Ulcerative colitis/Crohn's disease	☐	Hiatus hernia	☐
Liver function problems	☐	Stomach/duodenal ulcer	☐
Irritable bowel syndrome	☐	Severe indigestion	☐

Genito-Urinary Problems

Recurrent urinary Infections	☐	Kidney function problems	☐
Prostate problems	☐	Erectile dysfunction/problems	☐
Incontinence	☐	Abnormal smears	☐

Epilepsy

Do you have Epilepsy?		**Yes** ☐	**No** ☐
When did you last have a fit, approximately?		Please tick if you have been fit free for over 12 months.	☐
Roughly how often do you have fits?			☐

Diabetes - Which of the following are used to control your diabetes?

Diet alone	☐	Tablets	☐
Insulin	☐	Other injections	☐

Bone & Joint Problems

Hip replacement	Left ☐	Right ☐	Both ☐
Knee replacement	Left ☐	Right ☐	Both ☐
Other joint replacement (please state)			
Rheumatoid arthritis	☐	Osteoporosis (proven)	☐
Gout	☐		

HEALTH QUESTIONNAIRE continued

Mental Health Problems			
Depression	☐	Personality disorder	☐
Dementia	☐	Anxiety	☐
Schizophrenia	☐	Cognitive impairment	☐
Bipolar disorder	☐	Other psychotic illness	☐
Self harm/suicide attempt	☐		

Skin problems			
Eczema	☐	Psoriasis	☐
Ulcers	☐		☐

Other conditions	☐	Underactive thyroid	☐
Overactive thyroid	☐	Migraine (with aura e.g. weakness visual disturbance, numbness)	☐

For women			
Please tick if you use any of the following contraceptive methods			
Combined pill	☐	Mini-Pill or Cerazette	☐
Depo-Provera injections	☐	Copper coil	☐
Implant in arm	☐	Mirena coil	☐

Date of Last Cervical Smear _____	Result of Last Cervical Smear: Normal / Abnormal
If Abnormal, details of follow-up:	

Please provide a copy of your immunisation history

Any other significant medical problems or operations:

Signed: ☐	Date: ☐

For information:

NATIONAL DATA OPT-OUT (Sharing of your personal information for purposes other than your own direct care)

NHS Digital collects health information from GP records, hospitals and other healthcare providers for planning and research purposes - sometimes this data includes information that could identify you. You are entitled to opt-out of your data being used in this way. Making this choice won't affect the care you receive in any way.

You can opt-out online on the NHS Choices website www.nhs.uk from 25th May 2018. NHS Digital will be providing a non-digital alternative for patients who can't or don't want to use an online system.

The National Data Opt-out replaces the previous Type 2 opt-outs which patients registered with their GP. Further information can be found on the NHS Digital website at http://digital.nhs.uk/services/national-data-opt-out-programme.