

Scott Road Medical Centre Adult Registration Form

PLEASE COMPLETE THIS FORM IN FULL USING BLOCK CAPITALS

To register we require two forms of ID: Photo Identification and a Proof of Residency. This could be a passport or driving licence as well as a bank statement, council tax letter or utility bill.

Have you ever been registered at this practice before? Yes No

General Information	
Full Name	
Date of Birth	
My height	
My weight	

Contact Details	
Mobile Number	
Home Number	

I consent to receiving SMS text messages from Scott Road Medical Centre regarding appointment reminders and relevant health invitations. (Please tick) Consent Dissent

Email	
Email address	

We occasionally use your email address to communicate with you about your direct medical care.

We can also email you other useful information unrelated to your direct medical care - for example surgery newsletters, surgery information, staff changes and minutes from patient participation meetings.

Please tick here if you consent to Scott Road Medical Centre contacting you by email with Non-medical information

We never pass your email onto any third parties (unless you have given us your consent to do so) you can withdraw consent at any time by informing Reception.

Do you have repeat medication? If yes, Please provide us with a copy of your repeat medication list from your previous GP

Nominate a Pharmacy	Pharmacy Name & Location
We now send all prescriptions electronically to your preferred pharmacy, please nominate a pharmacy.	

Do you suffer from allergies or sensitivities?
If Yes, please provide details

Specific Needs: This is to enable us to accommodate your needs. Please specify any specific requirements you may need below.	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an Assistant Dog User?	
Please state any Physical/ Mental disabilities you have?	
Do you have any access requirements?	
Do you have any phobias?	

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	<u>Carer Contact Details:</u>
	<u>Person Cared for Contact Details:</u>
If you are a Carer, please state your name/address/phone number of the person who you care for:	

Employment status - Please tick the box that applies to you			
I am employed full time	<input type="checkbox"/>	I am unemployed	<input type="checkbox"/>
I am employed part time	<input type="checkbox"/>	I am retired	<input type="checkbox"/>
I am self employed	<input type="checkbox"/>	I am medically retired	<input type="checkbox"/>
I am a student	<input type="checkbox"/>		

Ethnicity – Please tick only 1 box			
White	British	<input type="checkbox"/>	XaJQv
	Irish	<input type="checkbox"/>	XaJQw
	Any other white background	<input type="checkbox"/>	XaJQx
Mixed	White & Black Caribbean	<input type="checkbox"/>	XaJQy
	White & Black African	<input type="checkbox"/>	XaJQz
	White & Asian	<input type="checkbox"/>	XaJR0
	Any other mixed background	<input type="checkbox"/>	XaJR1
Asian or British Asian	Indian	<input type="checkbox"/>	XaJR2
	Pakistani	<input type="checkbox"/>	XaJR3
	Bangladeshi	<input type="checkbox"/>	XaJR4
	Any other Asian background	<input type="checkbox"/>	XaJR5
Black or Black British	Caribbean	<input type="checkbox"/>	XaJR6
	African	<input type="checkbox"/>	XaJR5
	Any other background	<input type="checkbox"/>	XaJR8
Any Other Ethnic Background	Chinese	<input type="checkbox"/>	XaJR9
	Any other (please describe)		XaJRA
Please state your first language?	English <input type="checkbox"/> Polish <input type="checkbox"/> Other		

Family History - Please tick ANY box that applies to you	
A member of my family suffers from Diabetes E.g. Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from Hypertension e.g. Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from Heart Disease that started BEFORE they were 60 years of age e.g. Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from Asthma e.g. Father, Mother, Brother, Sister	<input type="checkbox"/>

Smoking status – Please tick only 1 box	
I am a smoker <input type="checkbox"/>	If you are a smoker and would like help in trying to stop smoking please contact North Yorkshire Stop Smoking Service on 01609 797272
I am an ex-smoker <input type="checkbox"/>	
I have never smoked <input type="checkbox"/>	
I am not willing to disclose <input type="checkbox"/>	

Alcohol screening (over 16's only)
1 unit = ½ pint of beer or 1 single shot of spirits. 1 small glass of wine = 1.5 units (136)

Number of units you drink per week =

We are required by the Clinical Commissioning Group (CCG) to ask all new patients aged 16 and over how much and how often you drink alcohol?

Please help us help you by completing this quick survey.

For each question tick the answer that applies to you.

If your answer to the first question is 'Never' there is no need to complete this questionnaire.

Part 1

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	Your score
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+	Your score
How often you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Your score

Part 2a – Please only complete Part 2a & Part 2b if you scored 5 or more in Part 1

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	Your score
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	Your score

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	Your score
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	Your score
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	Your score
Your score for Part 2a						

Score	0		2		4	
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	Your score
Has a relative/friend/Health Worker ever been concerned about your drinking and advised you to cut down?	No		Yes but not in the last year		Yes, during the last year	Your score
Your score for Part 2b						

Your score from Part 1	
Your score from Part 2a & b	
Your total score	

Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for improving services. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.

Yes I am interested in becoming involved in the Patient Participation Group and would like to be contacted by a representative from the group (please tick)

You can opt out at any time, please contact us here at the surgery. This will not affect any other care we provide for you.

Summary Care Record (SCR)

The objective of a Summary Care Record is to share key information from your GP records. This enables other NHS services such as A&E or Out of Hours to access your essential health information as and when required. This is particularly beneficial to you in an unplanned or emergency situation.

There are two types of Summary Care Records, which are 'Standard Core' and 'Enhanced Core'. Both require consent.

What is 'Standard Core' Summary Care Record?

This includes sharing your current and repeat medications, any allergies you suffer from and any harmful reactions to medication you have experienced.

I consent to share my 'Standard Core' Records I dissent to share my Records

What is 'Enhanced Core' Summary Care Records?

This includes sharing your 'standard core' records with additional information such as; reason for medication e.g. why a patient needs a particular medication, long term health conditions for e.g. Asthma, Diabetes, Heart problems and rare medical conditions, Significant/relevant medical history. (Past and present) e.g. procedures, operations and long term conditions, communication preferences e.g. interpreter required, email/text/braille only, End of life care info e.g. the patient may have their own care preferences, which will enable us to care for them more in line with their needs e.g. preferred place of death/DNACPR/advanced care plan. Vaccinations and immunisations e.g. details of previous vaccinations, such as Tetanus and childhood jabs. Personal preferences e.g. religious beliefs or legal decisions that you would like to be known.

I consent to share my 'Enhanced Core' Records I dissent to share my Records

Office use only XaXbZ Read code

I can confirm that I have read and understood all the details in this document and that the information I have supplied is up to date and accurate.

Signature of Patient Date: _____

Or

Signature on behalf of Patient: Date: _____