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| --- | --- |
| **NHS NUMBER** |  |
| **FIRST NAME** |  |
| **SURNAME** |  |
| **TITLE** | MR  MRS  MS  MISS  MX  OTHER: |
| **DATE OF BIRTH** |  |
| **GENDER** |  |
| **ADDRESS** |  |
| **PREVIOUS ADDRESS (UK OR INTERNATIONAL)** |  |
| **CONTACT DATAILS** | MOBILE  ALTERNATIVE NUMBER  EMAIL ADDRESS |
| **CONSENT FOR CONTACTING** | I GIVE CONSENT TO BE CONTACTED BY SMS, EMAIL AND POST  Yes  No |
| **EMERGENCY CONTACT INFORMATION** | NAME  RELATIONSHIP TO YOU  CONTACT NUMBER |

|  |  |
| --- | --- |
| **PRVIOUS GP REGISTRATION** | HAVE YOU PREVIOUSLY REGISTERED WITH THE GP  Yes  No  IF YES,  NAME OF SURGERY  ADDRESS OF SURGERY  IF NO,  DATE YOU FIRST CAME TO THE UK |
| **COUNTRY OF BIRTH** |  |
| **ETHNICITY** |  |
| **RELIGION** |  |
| **INTERPRETER REQUIRED** | Yes  No If yes, Language required- |

|  |  |
| --- | --- |
| **EXISTING MEDICAL CONDITIONS** | PLEASE LIST ANY MEDICAL CONDITIONS THAT WE NEED TO BE AWARE OF BELOW  I DO NOT HAVE ANY EXSISTING MEDICAL CONDITIONS |
| **DETAILS OF MEDICAL CONDITIONS** | PLEASE GIVE DETAILS OF YOUR MEDICAL CONDITIONS. IF YOU DO NOT HAVE ANY MEDICAL CONDITIONS PLEASE MOVE TO THE QUESTION BELOW. |
| **ALLERGIES** | YES, I HAVE ALLERGIES  NO I DO NOT HAVE ANY KNOWN ALLERGIES  IF YES, PLEASE STATE BELOW |
| **MENTAL HEALTH CONDITIONS** | PLEASE STATE BELOW THE DETAISL OF YOUR CONDITIONS  I DO NO HAVE ANY MENTAL HEALTH CONDITIONS |
| **LEARNING DISABILITY** | DO YOU HAVE A LEARNING DISABILITY?  YES  NO  MILD  MODERATE  SEVERE  REGISTERED ON THE LEARNING DISABILITY REGISTER YES  NO |
| **CARER INFORMATION** | I HAVE A CARER  I AM A CARER  OCCUPATIONAL CARER  INFORMAL CARER  NONE OF THE ABOVE |
| **REPEAT PRESCRIPTION MEDICATION** | I HAVE REPEAT MEDICATION  I DO NOT HAVE ANY REPEAT MEDICATION  IF YOU HAVE REPEAT MEDICATION PLEASE LIST BELOW  **PLEASE BE ADVISED YOU WILL NEED TO HAVE A MEDICATION REVIEW WITH A CLINICIAN BEOFRE WE CAN ISSUE ANY REPEAT PRESCRIPTION MEDICATION.** |

PLEASE COMPLETE THE ALCOHOL AUDIT BELOW

|  |  |  |  |  |  |  |
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| **AUDIT–C QUESTIONS** | **SCORING SYSTEM** | | | | | **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? | 1-2 | 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 |  |

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| **DO YOU SMOKE?** | NEVER SMOKED  EX-SMOKER  SMOKER  **IF YOURE AN EX-SMOKER WHEN DID YOU STOP SMOKING? ……………………………** |
| **DO YOU USE AN E-CIGARTTE/VAPE?** | NEVER  SOMETIMES  ALL THE TIME |
| **WOULD YOU LIKE HELP TO QUIT SMOKING** | WE HAVE A SMOKING CESSATION SERVICE WITHIN THE SURGERY. WOULD YOU LIKE US TO SCHEDUALE AN APPOINTMENT FOR YOU  YES  NO |

|  |  |
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| **NOMINATED PHARMACY** | AT ARBURY ROAD SURGERY WE SEND OUR PRESCRIPTIONS ELECTRONICALLY DIRECTLY TO A PHARMACY OF YOUR CHOICE  PLEASE NOMINATE A PHARMACY BELOW |

**SHARING CONSENT**

**IF YOU ARE UNSURE WHAT THIS MEANS PLEASE ASK A MEMBER OF THE RECEPTION TEAM FOR AN INFORMATION PRINT OUT.**

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| **DO YOU GIVE CONSENT TO YOUR GP PRACTICE SHARING YOUR HEALTH RECORDS WITH OTHER ORGANISATIONS WHO CARE FOR YOU?**    YES I GIVE CONSENT (RECOMMENDED OPTION)  NO I DO NOT CONSENT. | |
| **DO YOU CONSENT TO YOUR GP PRACTICE VIEWING YOUR HEALTH RECORD FROM OTHER ORGANISATIONS THAT CARE FOR YOU?**  YES I GIVE CONSENT (RECOMMENDED OPTION)  NO I DO NOT CONSENT. | |
| **SIGNATURE** |  |
| **PRINT NAME** |  |
| **DATE** |  |

**ONLINE SERVICES AT ARBURY ROAD SURGERY**

IF YOU WISH TO, YOU CAN NOW USE THE INTERNET (VIA COMPUTER OR MOBILE APP) TO BOOK APPOINTMENTS WITH A GP, REQUEST REPEAT PRESCRIPTIONS FOR ANY MEDICATIONS YOU TAKE REGULARLY AND LOOK AT YOUR MEDICAL RECORD ONLINE. YOU CAN ALSO STILL USE THE TELEPHONE OR CALL IN TO THE SURGERY FOR ANY OF THESE SERVICES AS WELL. IT’S YOUR CHOICE.

IF THIS IS A SERVICE YOU WOULD LIKE TO GAIN ACCESS TOO PLEASE ASK THE RECEPTION STAFF FOR A FORM TO COMPLETE. PLEASE BE ADVISED WE WILL NEED TO SEE A FORM OF PHOTOGRAPHIC ID BEFORE WE CAN ENABLE THIS SERVICE. THIS IS FOR DATA PROTECTION.

**Practice Use Only**

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| Appointment | Required | Not Required |  |  |
| Provided NHS Number | Yes, No ID seen | No, Asked for ID | **\*\*please record below what ID has been seen\*\*** |  |
| Photo ID | Passport | Driving licence | Identity card | Other  No ID seen |
| Proof of Address | Utility Bill | Council Tax | Bank Statement | Other |
| Checked By | Sign: |  | Date: |  |
| Entered on S1 by | Sign: |  | Date: |  |