

Do you have any special communication needs? 🞏 Yes 🞏 No

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other …………………………………………………………….

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Mrs 🞏 Miss 🞏 Ms **Gender:** 🞏 Male 🞏 Female 🞏 Indeterminate 🞏

Date of Birth (day/month/year) NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

Town & Country of Birth

 Post Code:

Address

Telephone number: Mobile number:

Email address:

**Please help us trace your previous medical records by providing the following information:**

Your previous address in UK

 Post Code:

Name of previous Doctor

while at that address

 Post Code:

Address of previous Doctor

**If you are from abroad:**

Your first UK address where

 Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

**Have you or any member of your immediate family ever served in the British Armed Forces (spent at least one day enlisted):**

Yes, I’m currently serving at:

Yes, I am a military veteran:

Yes, I am a member of a

military family:

Enlistment date(s) Service/

 Personnel number

**NHS Organ Donor registration:**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

🞏 Any of my organs and tissue or

🞏 Kidneys 🞏 Heart 🞏 Liver 🞏 Corneas 🞏 Lungs 🞏 Pancreas 🞏 Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please ask at reception for an information leaflet or visit the website* [*www.uktransplant.org.uk*](http://www.uktransplant.org.uk) *or call 0300 123 23 23*

**NHS Blood Donor registration:**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years 🞏

Signature to confirm consent to inclusion on the NHS Blood Donor Register:

……………………..………………………………………………………………… Post code: ………………….

**Please tell us about yourself:**

Are you a carer? 🞏 Yes 🞏 No Do you have a carer? 🞏 Yes 🞏 No

If yes, please tell us the name & address of your

Carer / Agency:

Are you happy for your carer to book appts, collect prescriptions and other 🞏 Yes 🞏 No

paperwork for you?

Are you Housebound?   🞏 Yes 🞏 No

Do you live in a Residential home? 🞏 Yes 🞏 No

**Medication Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |

If you have a copy of your repeat medications, please pass to Reception to copy

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
| Please tell us who your Nominated Pharmacy will be: **Lifestyle ……** |  |

Please enter your height & weight:

|  |  |
| --- | --- |
| Height: | Weight: |

**Lifestyle smoking ……**

Do you smoke 🞏 Yes 🞏 No

Have you ever smoked? 🞏 Yes 🞏 No

How many cigarettes/ 🞏 <1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

cigars do you smoke daily?

Would you like help to quit smoking? 🞏 Yes 🞏 No

**Lifestyle exercise ……**

Do you exercise: 🞏 Yes 🞏 No

Would you consider it to be LIGHT / MODERATE/ HEAVY exercise – *please circle*

**Female patients only ……**

**vej**

Are you currently, or think you may be pregnant 🞏 Yes 🞏 No

**Ethnicity ……**

**vej**

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

**Next of kin ……**

**vej**

Name: Tel. contact

 number:

Relationship:

**How we contact you / Online access to your records**

To make contacting you easy and quick we will contact you using any of the methods listed below.

If you DO NOT want to be contacted in those ways, please indicate by ticking the box you DO NOT want to be contacted by below. We will also create and online account for you unless you tell us otherwise.

By email 🞏 Yes 🞏 No This will be to send you letters, newsletter and the like

By text 🞏 Yes 🞏 No This will be to send you reminders of Appointment’s via text etc

By phone 🞏 Yes 🞏 No This will be to book appointments, remind you of things etc.

Online Account 🞏 No Book your appointments, request medication, view records 24/7 etc

**Signature ……**

**vej**

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient 🞏 Signature on behalf of patient 🞏

**Data Sharing**

Please ensure you have read and understood our Privacy Notices. They explain how and when we use your information when providing care and communicating with you. If you are unclear about the potential implications please ask us and we will clarify as best we can. I confirm that I have read and understood the Privacy Notices in place at the East Shore Partnership.

**Name: Date of Birth:**

**Address: Signature:**

Having read and understood the Privacy Notices in place at the East Shore Partnership I would like to object to my data being shared in the following instances. Tick those relevant and we will advise you on the next steps.

|  |  |
| --- | --- |
| **Privacy Notice** | **Objection** |
| Direct Care, (routine care and referrals) |  |
| Direct Care - Emergencies |  |
| National screening programs |  |
| Commissioning, Planning, Risk Stratification, Patient Identification |  |
| Care Quality Commission |  |
| Summary Care Record – Basic Level |  |
| Summary Care Record – Enhanced Level |  |
| NHS Digital Type 2 HSCIC | **OBJECTIONS CAN ONLY BE MADE BY CALLING 0300 303 5678** |
| Payments |  |
| Public Health |  |
| Research |  |
| Safeguarding | **NO RIGHT TO OBJECT** |

**Name: Date of Birth:**

**Address:**

**Signature:**

**AUDIT–C**

**This is one unit of alcohol…**

Half pint of “regular” beer, lager or cider

Half a small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

**2**

Pint of “regular” beer, lager or cider

Alcopop or a 275ml bottle of regular lager

**1.5**

440ml can of “regular” lager or cider

**2**

440ml can of“super strength” lager

**4**

75cl Bottle of wine (12%)

**9**

Pint of“strong” or
”premium” beer, lager or cider

**3**

250ml glass of wine (12%)

**3**

**…and each of these is more than one unit**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 |  |

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking.

**SCORE**

An overall total score of 5 or above is AUDIT-C positive.

**Score from AUDIT- C (other side)**

**SCORE**

**Remaining AUDIT questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **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 |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk,

**TOTAL = =**

 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals

AUDIT C Score (above) +

Score of remaining questions

|  |  |
| --- | --- |
| Identity verified through(tick all that apply) | [ ]  Birth certificate[ ]  Photo ID (if available)[ ]  Proof of residence |
| Name of Verifier |  | Date |  |
| Person registering on SystmOne |  | Date |  |

**Consent to Share Confidential Information with a Third Party**

The Data Protection Act 2018 and the ethical codes of conduct of all health care professionals require that medical data be treated with great respect for confidentiality. We are not permitted to share any medical details with a third party without your consent

**Patient Details:**

|  |  |
| --- | --- |
| Patient Name:  |  |
| Date of Birth:  |  |
| NHS Number:  |  |

**I give consent to the sharing of my medical information with:**

|  |  |
| --- | --- |
| Full Name |  |
|  DOB |  |
| Contact Telephone Number |  |
| Relationship to patient |  |

**What type of information can be shared:**

|  |  |
| --- | --- |
| All | Yes [ ]  No [ ]  |
| Test Results | Yes [ ]  No [ ]  |
| Appointment Information | Yes [ ]  No [ ]  |
| Medications | Yes [ ]  No [ ]  |
| Other: |  |

**Please tell us if this consent is permanent or for a short period of time**:

|  |  |
| --- | --- |
| Permanent | Yes [ ]  No [ ] If no, please state - Start Date: End Date:  |

**Patient Signature** …………………………………………………………….

**Date**

**Please note: -** It is your responsibility to inform us if you change your mind and wish to remove your consent to share your medical information with the above mentioned person.