THE VERNON STREET & LANES MEDICAL CENTRE

Registration Booklet

Title …… Full Name ……

Previous surname (if any)…….…… DOB ……

Marital Status Married / Single / Widow / Divorced

Male / Female

NHS no: ……

Address……

……

Postcode……

Previous Address

Address……

……

Postcode……

Place of birth ……

If you are from outside of the UK

Your first UK address where you registered with a GP if you were previously living aboard

Date you first came to live in the UK:……

If previously a resident in the UK

Date left:…… Date returned:……

If you are returning from the Armed Forces:

Service or personal number:……

Enlistment date:……..

Name of Previous doctor……

Address of previous doctor……

Email Address ……

Do you consent to receive emails? (Please Circle) Yes No

*Please see note on back page regarding online access

Mobile Telephone No ……

Home Telephone Number ……

Do you consent to receive SMS Messages? (Please Circle) Yes No

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Next Of Kin (Name)..... **Relationship**: .....

Address (if different) ……

Contact Telephone No ……

Do you consent for your medical records to be shared with this person) Yes No

Mothers Details (for children under 16, if not stated above)

Name ……

Contact Telephone No ……

Fathers Details (for children under 16, if not stated above)

Name ……

Contact Telephone No……

Does father have parental responsibility? (Please Circle) Yes No

Ethnic Origin and Language

Please specify your Ethnic origin ……

Please specify your **MAIN SPOKEN** language ……

English Speaker (Please Circle) Yes No

Assistance During Appointments

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following: -

First language **NOT** English – require a translator (Please Circle) Yes

Deafness – require a sign language translator (Please Circle) Yes

Disability – require a carer to attend (Please Circle) Yes

Carer

Are you a Carer? (Please Circle) Yes No

If yes please provide details of person you **care for**

Name ……

Address ……

Contact No……

Do you have a Carer? (Please Circle) Yes No

If yes please provide details of your carer

Name ……

Address……

Contact No……..

Would you like access to help and support? (Please Circle) Yes No

THE VERNON STREET & LANES MEDICAL CENTRE

How many units of alcohol do you drink Per Week? _____ Units

Please Circle below

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 standard 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 Nearly Daily

Smoking Status

Do you Smoke? (Please Circle) Yes No

If yes, what do you smoke? (Please Circle) Cigarettes / Cigar / Pipe

If you are a smoker how many do you smoke each day? ……

Do you use electronic cigarettes? (Please Circle) Yes No

Would you like to quit smoking? (Please Circle) Yes No

Would you like advice about how to quit? (Please Circle) Yes No

If you are an ex-smoker what date did you give up? .....

Do you have any Allergies? (Please Circle) Yes No If yes, please list below

……

Female Patients Only

In order that we can arrange the correct follow-up, please let us know if you are using either of the following contraceptive devices:-

IUCD (coil) (Please Circle) Yes Date of insertion……..

Implanon / Nexplanon (Please Circle) Yes Date of insertion……..

Have you had a cervical smear? (Please Circle) Yes No

Date of your last smear……

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TB Screening Programme: if you are aged between 16 and 35 Years and moved to the UK within the last 5 years please complete the questions below:

Date of entry to UK ……..……

Which Country did you come from? ……..…….

How long did you live in that Country for? ……..

Have you ever used Intravenous drugs? (Please Circle) Yes No if yes add date: ……

Have you ever abused alcohol? (Please Circle) Yes No if yes add date: ……

Have you ever been homeless? (Please Circle) Yes No if yes add date: ……

Have you ever had a prison record? (Please Circle) Yes No if yes add date:

Have you ever had one of the following conditions?	**YES/NO**	**Year**
Epilepsy		
High blood pressure		
Heart Attack		
Angina		
Stroke		
Transient ischaemic attack		
Cancer		
Rheumatoid Arthritis		
Mental illness		
Diabetes (type 1 or type 2)		
Asthma		
COPD (or Emphysema)		
Osteoporosis		
Peripheral vascular disease		

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Please list any serious illnesses /operations/accidents/disabilities (women: any pregnancy related conditions) & year they took place:

Do you have any family history of any of the following?

	YES/NO	Relationship
High blood pressure		
Ischaemic Heart Disease Diagnosed over 60 years		
DVT/Pulmonary Embolism		
Breast Cancer		
Other Cancer Specify type:		
Raised cholesterol		
Stroke/CVA		
Asthma		
Thyroid disorder		
epilepsy		
Osteoporosis		

THE VERNON STREET & LANES MEDICAL CENTRE

Your Electronic Patient Record and the Sharing of Information

Your healthcare services (which can include your GP practice, child health, community services – including District Nurses, palliative care services, urgent care teams and more) all use computer systems which allow the GP's , consultants, nurses and other healthcare staff to record patient information securely.

Not all of this information is currently shared between the different units. This can mean that important information is not visible to the health professional who is treating you.

What does the sharing of information mean to me?

By completing the Sharing Consent Form on the next page, we can record how you want to control the sharing of your medical information in to us, and out to authorised staff who have secure access at different units within the healthcare environment.

We are asking for your consent or dissent for:

1) Your information entered at our Practice to be shared with other healthcare workers within their healthcare settings.
2) Information about you that has been recorded by other health services caring for you to be shared to us at your GP Practice. Your clinician will be able to tell you the services that currently

Note: You can **request individual entries** in your record to be marked as private. These will not then routinely be shared with other services.

Don't Forget: These controls apply to many NHS services using a system that is capable of sharing patient information. You can change your sharing preferences at any time by speaking to a member of NHS staff at the care service you are attending.

How does this work?

Imagine that you are receiving care from three different NHS services: a GP, district nurse and NHS smoking clinic. You want your GP and district nurse to be able to share information with each other, and know your progress at the smoking clinic. However you don't want the smoking clinic to see any of your other medical information.

The GP can share information IN and OUT. The district nurse can share information IN and OUT. The smoking clinic can only share information OUT but not IN.

Sharing Consent Form

Our computer system is used by lots of other health units too. When there is another service seeing you, we need to know if you are happy for us to share information that is held on their computers.

We have 2 questions for you

Are you happy for your information on our computer to be seen by others treating you elsewhere? (Please Circle) Yes No

Are you happy for us to see your information from other services? (Please Circle) Yes No

Name ……

Signed……

Date ……..

Signed on behalf of patient (if applicable (e.g. minors under age, adults lacking capacity)

Relationship to patient……

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Summary care Record

Do you consent to sharing your NHS Summary Care Record (SCR)? i.e. will you allow other health professionals working with the Practice to access to your records if necessary for your healthcare? District Nurses, A&E, Derby Hospital, physio- therapists, Community Matrons etc. (there is both basic & advanced information to be able to share)

Basic-allergies, reactions & medications (Please Circle) Yes No

Advanced-as above plus significant problems, significant procedures, Anticipatory care, end of life, immunisations (Please Circle) Yes No

More details concerning the summary care record and what it means to you can be found by visiting: www.nhscarerecords.nhs.uk
Do you consent to receiving emails & text messages?

Name ……
Signed……
Date ……..
Signed on behalf of patient (if applicable (e.g. minors under age, adults lacking capacity)
Relationship to patient……

THE VERNON STREET & LANES MEDICAL CENTRE

The Vernon Street Medical Centre

Registration for Online Services

I wish to have access to online services Yes No

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. 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:**

For Practice use only

Identification Provided Staff Member Name:……. Signed……..
Photo ID verified ☐ Document presented…….
Date:

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We offer an **Electronic Prescribing Service** where your prescription is sent **direct to a Pharmacy**
Which pharmacy would you like to nominate?……..

Pharmacy Address ……

Additional Information
Height: Weight:

As a practice we offer new patient check appointments, would you like to book one?

(Please Circle) Yes No

Are you taking any regular medication? Please list: (use additional sheet if required)

NHS Organ Donor Registration/Blood Donor Registration
I want to register my details on the NHS Organ donor register as someone whose organs may be used for transplantation after my death. Please tick which apply to you. Any other information please visit the website www.uktransplant.org.uk or call 0300 123 2323.
(Please Circle) Yes No
If yes please complete the following:
Any of my organs and tissue or specify-
Kidneys / Heart / Liver / Corneas / Lungs / Pancreas /Any part of my body

I would like to join the blood donor register (Please Circle) Yes No

Have you given blood in the last 3 years (Please Circle) Yes No

Patient participation group (PPG)
The practice has an active group of patients that work with the practice to improve our care and service. This is a virtual group and all patients are welcome to join.
Would you like to join this group (Please Circle) Yes No

Accessible Information
Do you need information in an accessible format Yes No

LARGE PRINT **BRAILE** **AUDIO** **SMS** **BSL** **EASY READ** **OTHER FORMAT**

Signed on behalf of patient (if applicable) (e.g. minors under 16 years old, adults lacking capacity)	**Relationship to Patient :**

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IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS AS A NEW PATIENT

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this.

PROOF OF NAME
(One of the following)

Birth Certificate
Marriage Certificate
Driving Licence (valid)*
Passport (Valid)*

PROOF OF ADDRESS; MUST BE DATED WITHIN THE LAST 3 MONTHS
(One of the following)

Utility Bill
Council Rent Book
Bank Statement
Credit Card Statement
Letter from Benefits Agency

***Please note if applying for Online Access to your medical records, photo ID must be produced.**

For Practice use only

Patient NHS number		
Named GP		**Identification Provided**
Identity verified by (initials)	Date	Address verified ☐ Document presented…… Photo ID verified ☐ Document presented……
Authorised by:		Date:
Date record created:		

AVAILABLE IN ALTERNATIVE FORMATS ON REQUEST