Pimlico Health @ The Marven

Accessible Care | Greeted Friendly | Welcomed Professionally | Treated Respectfully

New Patient Registration Form (Adult: 16 and over)

Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

Today's Date:

<table>
<tr><td rowspan="11">1</td><td colspan="4">Full Name:</td><td colspan="3">Telephone Number:</td></tr>
<tr><td>Title : Mr ☐</td><td>Mrs ☐</td><td>Miss ☐</td><td>Ms ☐</td><td colspan="3">Work tel. number:</td></tr>
<tr><td colspan="4">Other. Please state :</td><td colspan="3" rowspan="2">Mobile tel. number:

We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive text messages from us: ☐</td></tr>
<tr><td colspan="4" rowspan="3">Address:

Postcode:</td></tr>
<tr><td colspan="3">Name of Next of Kin/Relationship</td></tr>
<tr><td colspan="3">Next of Kin contact tel. number:</td></tr>
<tr><td colspan="4">E-mail address:</td><td colspan="3">Maiden name / Mothers name if different:</td></tr>
<tr><td colspan="3" rowspan="2">How would you prefer us to contact you:
Letter ☐ Email ☐
SMS (text) ☐ Phone ☐

Would you like to register for online access? Yes/No
Please ask at reception for log on details once registered.</td><td colspan="4">Marital Status:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Gender:
Male ☐
Female ☐
Transgender ☐
Gender Fluid ☐</td></tr>
<tr><td colspan="7">Town* and Country of birth (*If town is London please state which Borough) Country: Town: Borough (*If born in London):</td></tr>
<tr><td colspan="2">Please list other residents of your home who are registered with us:</td><td colspan="2">Name:</td><td colspan="3">Date of Birth:</td></tr>
</table>

2	Looking After A Family Member	
	Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	Yes ☐ No ☐
	Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	Yes ☐ No ☐
	Carer's name:	Relationship to you:
	Telephone number of carer:	Is your carer registered with us?
	Address of carer:	

3	Are You Currently Employed?			
	If so please specify whether :	Full-time ☐	Part-time ☐	Self-employed ☐
	If you are not employed, please indicate which best describes you:			
	Retired ☐	Student ☐	Housewife/ Homemaker/House husband ☐	Unemployed ☐
	Other ☐ *Please state*:			
	If returning from the Armed Forces please state which below: • Army ☐ • Royal Navy ☐ • Royal Air force ☐			Comments:

4	Your Religion (Please tick)					
	C of E ☐	Catholic	Other Christian (state): ☐	Buddhist ☐	Hindu ☐	Muslim ☐
	Sikh ☐	Jewish	Jehovah's Witness ☐	No religion ☐	Other religion (state) ☐	
	Your Ethnic Origin (Please tick one)					
	Black Caribbean/British ☐	Indian / British Indian ☐	Arabic ☐	White (UK)		
	Black African /British ☐	Pakistani / British Pakistani ☐	Chinese ☐	White (Irish)		
	Other Black Background ☐	Bangladeshi / British Bangladeshi ☐	Other ☐	White (Other)		
	Other Mixed Background ☐	Other Asian Background ☐		Ethnic Category Refused ☐		

	Do you need an Interpreter? (Please tick)				
	Arabic ☐	Hindi ☐	Urdu ☐	Bengali /Sytheti ☐	
	Polish ☐	Farsi ☐	French ☐	Portuguese ☐	
	Guajarati ☐	Punjabi ☐	Other language. ☐ *Please state*:		
	Do you need help with mobility/hearing/speaking? (tick all that apply)				
	Wheelchair ☐	Walking aid ☐	Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐
	Lip reading: ☐	Large print: ☐	Braille ☐	Other. *Please state*:	
	Are you currently?	Homeless ☐	A Refugee ☐	An Asylum Seeker ☐	
	Are you an 'Assistance Dog' User?		Yes ☐	No ☐	
	Are you housebound?		Yes ☐	No ☐	

5	Women Only	What is the date of your last *Smear test*?	Date:	Result:
	Was this at your GP Surgery?	Yes ☐ No ☐	Date of last *Mammogram* (if applicable):	
	Number of *pregnancies* (include miscarriages & terminations) (If applicable)			
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			Yes ☐ No ☐

Cytology Form

Notification of last cervical screening test (NHS or non NHS) and total hysterectomy

GP……Code number ……E87034……

The patient named below has informed us of her last cervical smear test /
Date of hysterectomy. Please update the woman's screening history at the CCG.

Surname ……First name(s) ……...

Date of Birth……NHS number ……..

Address ……..

……

Date of Registration ……

Last smear test / total hysterectomy ……

Taken by NHS clinic – Privately – Abroad **delete as appropriate*

Result ……Date next test due……

To be referred to colposcopy / gynecology follow up in ……..……months

Patient to be called in for cervical screening on ……..

Patient refuses / does not require cervical screening – postpone for ……years

GP / Nurse signature ……Date ……

Patient signature ……Date……

6	Your Medical Background				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply *and* state family member:				
	Diabetes ☐ Who:	Asthma ☐ Who:	Thyroid disorder ☐ Who:	Stroke ☐ Who:	COPD ☐ Who:
	Heart Attack under age of 60 ☐ Who:	Cancer (Specify type) ☐ Who:	High Blood pressure ☐ Who:	Any other important family illness.	Who:
	Please state any allergies and sensitivities you have to medicines, food & dressings:				
	Please state any mental disabilities you have:				
	Are you able to administer your own medicines?	Yes ☐ No ☐	*If no* please give details, e.g. swallowing or opening containers:		
	What chronic medical conditions have you had?				Date of Diagnosis:
	What operations have you had?				Date of operation/s:
	What injuries have you had?				Date of injury/s
	Please list any tablets, medicines or other treatments you are currently taking / undertaking:				

7	We provide electronic prescribing, which means your prescriptions are send via computer to you preferred choice of pharmacy, ready for your collection. Would you like to select your most convenient pharmacy to collect your prescriptions from?
	Yes ☐ No ☐ If Yes Which is the name of this pharmacy?

8	Sexual Orientation
	Gay ☐ | Lesbian ☐ | Bisexual ☐ | Heterosexual ☐ | Asexual ☐

9	Lifestyle		
	Are you currently a smoker? Have you ever been a smoker?	Yes ☐ Yes ☐	No ☐ No ☐
	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a week?		
	Cigarettes:	Cigars:	Tobacco:
	If you are a smoker and want to STOP please tick here: ☐		

Alcohol Consumption – Audit C Form

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	

Scoring: A total of 5+ indicates increasing or higher risk drinking | An overall total score of 5 or above is AUDIT-C positive.

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 | 16 – 19 Higher risk, 20+ Possible dependence.

10	Diet and Exercise			What type of diet do you have?	
	How much exercise do you do?			Healthy	☐
	Sedentary	(No exercise)	☐	Unhealthy	☐
	Gentle	(climbs stairs, walking , gardening)	☐	Vegan	☐
	Moderate	(Cycling, swimming regularly)	☐	Vegetarian	☐
	Vigorous	(Attends gym regularly)	☐	Moderate	☐

Please enter your height in		Please enter your weight in	
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:

11	Sharing Your Medical Record
	Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record. If you don't want to share your GP record tick here: ☐
	Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. If you don't want to have a Summary Care Record tick here: ☐
	The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*: ☐ I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*: ☐

12	Patient Participation Group (PPG)	
	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 making services better • 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 • If you are interested in getting involved in the PPG, please tick yes in the box below and we will arrange for the Practice for the Practice Patient Participation Group Application Form to be given to you at your initial consultation	
	<u>Yes</u> I am interested in becoming involved in the PPG ☐	<u>No</u> I am not interested in becoming involved in the PPG ☐

13	Other Information		
	Do you have a "*Living Will*"? (A statement explaining what medical treatment you would not want in the future)?	Yes ☐ No ☐	*If "Yes"*, can you please bring a written copy of it to your first appointment?
	Have you nominated someone to speak on your behalf (*e.g. a person who has Power of Attorney*)? Yes ☐ No ☐	*If "Yes", <u>please state</u>* their Name: Address: Phone number:	

Patient Online Access Form

I reserve the right to reverse any decision I make in granting proxy access at any time.
I understand the risks of allowing someone else to have access to my health records.
I have read and understand the information leaflet provided by the practice.

Online appointments booking/cancellations	☐
Online repeat-prescription management	☐
Viewing Online coded medical record	☐

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	☐
I will be responsible for the security of the information that I/we see or download	☐
I will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	☐
Signature	**Date**

For practice use only

The patient's NHS number		**The patient's practice computer ID number**
Identity verified by **Access authorised by** **Account created** **Date passphrase sent**	**Date**	**Method of verification** Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Notes / comments on access	**Level of record access enabled** Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐	

Thank you for completing this form. For more information about the services we offer, please refer to our practice website: www.pimlicohealth.co.uk