

**APPLICATION TO JOIN ELBURY MOOR MEDICAL CENTRE**

**REGISTRATION PACK**

**Welcome to Elbury Moor Medical Centre**

We are pleased to welcome you to the practice. As part of your registration there are several forms for you to complete.

**REGISTRATION FORM**

It is important that this form is fully completed correctly, if failed to do so it may delay your registration with the practice.

**APPOINTMENTS ONLINE**

We offer a service where you can book appointments online, please ask one of our receptionists for more details.

**PATIENT HEALTH QUESTIONNAIRE**

This will include any relevant medical history about yourself as it may take time for your previous notes to be transferred to our system.

**NHS HEALTH CHECK**

For patients over the age of 40, the surgery will contact you to arrange a free NHS health check appointment within 6 weeks of your registration.

**WEBSITE**

For any further information on the practice please find our website below.

 

The receptionists are always here to help you. If you require any further assistance regarding your registration or if you have any further questions regarding the practice please do not hesitate to ask.

**Website address**: [www.elburymoor.co.uk](http://www.elburymoor.co.uk)

**Telephone:** 01905 723441

**Dr Taylor & Partners - Elbury Moor Medical Centre**

# New Patient Registration Form

**Today’s Date:**

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

Please complete a separate form for each family member to be registered.

|  |  |
| --- | --- |
| **Full Name:** | **Telephone Number:** |
| **Mr / Mrs / Miss / Ms / Other……..** | **Work Number** |
| **Address and Postcode:**

|  |
| --- |
| **Please tick your preferred method of contact:** |
|  |
| Home telephone |   |   |
| Mobile telephone |   |   |
| Work telephone |   |   |
| Letter to home address  |   |   |
| No preference  |   |   |
|  |  |  |
|  |  |  |

 | **Mobile Number:** |
| **E-mail Address:** |
| **Next of Kin:** |
| **Next of Kin Contact Number:** |
| **Date of Birth:** | **Previous / Mother’s surname if different:** | **Town & Country of Birth** |
| **Marital Status:** |  | **Gender:** | **Male:** | **Female:** | **Other residents of your home:** |
| **Occupation:** |
| **Names & Ages of Children:** |
| **Housing****(Select one)** | **House** | **Maisonette** | **Flat** | **Mobile Home** | **NHS Number (If Known)** |
| **Previous Address:** | **Previous Postcode:** |
| **Previous Doctor Telephone No.** |
| **Previous Doctor Name & Address:** | **Previous data released?** | **Yes** | **No** |
| **If applicable, date you** **first came to live in Britain:** |
| **If returning from** **Armed Forces:** | **Your Service or Personnel Number** | **Your Enlistment Date** |
| **Your****height:** | **Feet / inches** | **cm** | **Your****weight:** | **Stones / lbs.** | **kg** |
|  |
| **Your****Religion:** | **C of E** | **Catholic** | **Other Christian (state)** | **Buddhist** | **Hindu** | **Muslim** |
| **Sikh** | **Jewish** | **Jehovah’s Witness** | **No religion** | **Other religion (state)** |
|  |
| **Your Ethnic Origin:****(select one)** | **White (UK)**  | **White (Irish)** | **White (Other)** |
| **Caribbean** | **African**  | **Asian** | **Other Mixed** **Background**  |
| **Indian /** **Brit Indian**  | **Pakistani /** **Brit Pakistani** | **Bangladeshi / Brit Bangladeshi**  | **Other Asian** **Background**  |
| **Other Black** **Background** | **Chinese**  | **Other**  | **Ethnic Category** **not stated**  |
|  |
| **Your main or 1st language Spoken / Understood:****(select one)** | **English** | **Hindi** | **Gujurati** | **Urdu** | **Bengali /Sytheti** | **Punjabi** |
| **Polish** | **Ukrainian** | **French** | **German** | **Spanish** | **Other:****(Please****Specify)** |
|  |
|  Please complete our alcohol screening test. Even if you do not drink and have never consumed alcohol, we still need your answers for our records.**Fast Alcohol Screening Test (FAST)****This is one unit of alcohol…****…and each of these is more than one unit**

|  |  |  |
| --- | --- | --- |
|  | **Scoring system** |  |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| **Only answer the following questions if the answer above is Never (0)** |
| 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 been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 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 |  |

**Remaining Alcohol Questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** |  |
| **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? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |  |
| 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 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 |  |
| 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 |  |

**WELLBEING REVIEW****Please circle the appropriate number against each of the questions below:** |
|  |
| Your Medical Background: |
| **What illnesses have you had & When?** |  |
| **What operations have you had and When?** |  |
| **Do you have any medical problems at present?** |  |
| **Please list any tablets, medicines or other treatments you are currently taking:****(incl. dose + frequency)** |  |
| **Are you able to administer your own medicines?** | **Yes** | **No – please detail specific issues (e.g. swallowing, opening containers)** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any** **serious diseases that affect your Parents, Brothers or Sisters** **(tick all that apply)** | **Diabetes** | **Heart Attack** | **Heart attack under age of 60** | **Bowel Cancer** |
| **Breast Cancer** | **High Blood Pressure** | **Asthma** | **Stroke** |
| **Thyroid Disorder** | **Any other important Family Illness?** |
|  |
| **What immunisations have you had? (please tick all that apply)** | **Diphtheria** | **Meningitis** | **Tetanus** | **Polio** | **MMR** |
| **Whooping Cough** | **Pre-school booster** | **Triple vaccine (Diphtheria,** **Tetanus & Pertussis) –** **3 doses** |
|  |
| **Specific Needs:****Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** |
| **Please state any Sensory Impairment you have** **(i.e. Speech, Hearing, Sight):** |  |
| **Are you an ‘Assistance Dog’ User?** |  |
| **Please state any Physical disabilities you have:** |  |
| **Please state any Mental disabilities you have:** |  |
| **Please state any requirements you have to be able to access the Practice premises** |  |
| **Please state any Religious or Cultural needs:** |  |
| **Do you require the help of a Translator / Interpreter?** |  |
| **Please state any specific nutritional requirements you have:** |  |
| **Please state any allergies and sensitivities you have:** |  |
| **Please state any phobias you have:** |  |
| **If you are a Carer, please state the name / address / phone number of the person you care for:** | **Person Cared For Contact Details:** |
| **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.** | **Carer Contact Details:** |
|  **Signed: Date:** |
| **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 consultation*** |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | **Yes / No** | **If “Yes”, please state their name / address / phone number:** |
|  |
| **Women only:** |
| **When was your last smear done?** | **Date** | **Was this at your** **GP’s Surgery?** | **Yes** | **NO** |
| **What was the result** **of the smear?** |  |
| **Date of last mammogram****(if applicable):** | **Date** | **Method of contraception (if used):** |  |
| **Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?** | **Yes** | **NO** |
|  |
| **Summary Care Records.****The NHS are changing the way your health information is stored and managed.** **The NHS Summary Care record is an electronic record of important information about your health.** **It will be available to health care staff providing your NHS Care. An information pack has been provided.** |
|  |
| **Are you happy to have a Summary Care Record?** | **Yes** | **No** | **More Time Required to decide:** |
|  |
| **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 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, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.**  |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the “Yes” Box)** | **Yes** |
|  |
| **Patient****Signature:** |  | **Signature on****behalf of Patient:** |  |

For new patients aged 40+ - Your NHS Health Check will be informed by letter or telephone. If you cannot make the appointment date please inform the Practice and we will be able to offer an alternative time and date.

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

* ***Medical factors - illnesses, immunisations, allergies, hereditary factors, current health***
* ***Lifestyle factors - diet and exercise, smoking and alcohol.***

***The examination will take blood which will review:***

 ***Females: HbA1C – Diabetes Check***

 ***Random Cholesterol – there is no need to fast for this test***

 ***Males: HbA1C – Diabetes Check***

 ***Random Cholesterol – there is no need to fast for this test***

**Thank you for completing this form**

***For more information about the services we offer, please refer to your new patient pack
 or see our website: www.elburymoor.co.uk***

***ELBURY MOOR MEDICAL CENTRE***

***TEXT MESSAGING CONSENT FORM***

***If we have your mobile number and your consent we can now send you a free text message to remind you that you have an appointment with us.***

***With your consent, we can also text you at other time, for example, instead of sending a letter to remind patients to come in for their annual flu jab.***

***Please complete the form below and hand into our reception team if you are interested.***

|  |  |
| --- | --- |
| ***Patient Name*** |  |
| ***Date of Birth***  |  |
| ***Mobile Number***  |  |

***• I agree to the Practice communicating with me by SMS or text.***

***• I confirm that I will advise the Practice if I change my mobile number.***

***• I agree to receive a reminder of my appointment by SMS***

***• I am aware I can withdraw consent at any time by informing the practice in writing but I must give at least 5 working days’ notice.***

***Signature: Date:***

**Elbury Moor Medical Centre**

**Electronic Prescription Service**

**Would you like your medication sent to your local pharmacy?**

***NB: If you have moved into the area, please note that your nominated pharmacy will not be changed until you notify us.***

Pharmacy Name….

Pharmacy Address….

Pharmacy Post Code….

Patient Name…..

D.O.B……

Address…..

\*\*\*\***Please be aware you will still need to order your medication three days before either at your chemist or here at Elbury Moor Medical Centre\*\*\*\***

\*\*\*\* **Please be aware you will still need to order your medication three days before you run out either at your chemist or here at Elbury Moor Medical Centre \*\*\*\***