***MCj03616020000[1]Topsham Surgery***

**Application to register an NHS Patient with Topsham Surgery**

**Please use BLOCK CAPITALS and ensure all boxes are completed.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mr Mrs Miss Ms other | | Surname: |  | | |
| Date of Birth: |  | First names: |  | | |
| NHS No: |  | Previous name/s: |  | | |
| Male / Female |  | Town and country of birth: |  | | |
| Home Address: | |  | | | |
| Postcode: | |  | | | |
| Mobile Telephone number: | |  | | Home phone no: |  |
| Email address: | |  | | Work phone no**:** |  |

|  |  |
| --- | --- |
| Do you have any specific communication needs? E.G. Hearing Loss / Visual Impairment | If yes, please state below how you would like us to communicate with you and explain what communication support would be helpful for you. |

**PREVIOUS GP DETAILS**

|  |  |
| --- | --- |
| Your Previous address in the UK: |  |
| Name & Address of Previous GP |  |

**IF YOU ARE FROM ABROAD**

|  |  |  |  |
| --- | --- | --- | --- |
| Your first UK address where registered with a GP: |  | | |
| Date you first came to live in the UK: |  | If a previous resident in the UK – Date of Leaving: |  |

**IF YOU ARE RETURNING FROM THE ARMED FORCES**

|  |  |
| --- | --- |
| Have you ever served in the armed forces? | YES / NO |
| Service or Personnel Number: |  | Enlistment Date: |  |

**IF YOU ARE REGISTERING A CHILD UNDER THE AGE OF 16**

|  |  |
| --- | --- |
| Please provide name(s) of person(s) with parental responsibility: |  |
| Address/contact details if different from above: |  |
| If you are registering a child under 5, do you wish the above child to be registered with the Doctor for Child Health Monitoring? | YES / NO |

**NEXT OF KIN**

|  |  |
| --- | --- |
| Pleaseprovide name and contact detailsof the person we should contact in the case of an emergency.  Your medical details will not be shared with this person unless you give permission |  |
| What relationship is this person to you? |  |

**YOUR ETHNICITY AND LANGUAGE**

NHS organisations are required to collect details ethnic origin together with native or first language. This information is collected to fulfil that obligation and is used for monitoring purposes only.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| WHITE:  British or Mixed British |  | MIXED: White and Black African |  | ASIAN: Pakistani or British Pakistani |  | BLACK:  African |  |
| WHITE:  Irish |  | MIXED: White and Asian |  | ASIAN:  Bangladeshi or British Bangladeshi |  | BLACK:  Any other background |  |
| WHITE:  Any other background |  | MIXED: Any other background |  | ASIAN:  Any other background |  | CHINESE: |  |
| MIXED: White and Black Caribbean |  | ASIAN: Indian or British Indian |  | BLACK:  Caribbean |  | ANY OTHER ethnic group ………………………………… |  |
| I prefer not to specify my ethnic group. | | |  |  | | | |
| **What is your first spoken language?** We will record your first spoken language as ENGLISH unless you specify otherwise. | | | |  | | | |

**YOUR FAMILY HEALTH HISTORY**

Have your parents, brother(s) or sister(s) suffered from any of the problems listed below. Please tick and then **circle which family member** .

|  |  |  |
| --- | --- | --- |
| Diabetes |  | Father / Mother / Sister / Brother |
| Asthma |  | Father / Mother / Sister / Brother |
| High Blood Pressure |  | Father / Mother / Sister / Brother |
| Stroke |  | Father / Mother / Sister / Brother |
| Heart Disease |  | Father / Mother / Sister / Brother |

**YOUR OWN HEALTH**

HEALTH PROBLEMS: Please **tick if you have a history of any of the following** health problems……

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please give an estimated year of diagnosis if you have any of the following:** | | | |  |
| **Cancer** |  | **Coronary Heart Disease, Heart Failure, or Atrial Fibrillation** | |  |
| **Dementia or Alzheimer’s** |  | **Depression or Mental Health problems** | |  |
| **Hypertension (High Blood Pressure)** |  | **Kidney Disease** | |  |
| **Asthma** |  | **Stroke or Transient Ischemic Attacks** | |  |
| **COPD** |  | **Learning Difficulties** | |  |
| **Diabetes** |  | **Thyroid Disease** | |  |
| **Epilepsy** |  |  | |  |
| **If you have any other history or important illnesses or disabilities not mentioned above please give details here:** | | | | |
| **Are you awaiting any Hospital treatment? If yes please state.** | | |  | |

|  |  |
| --- | --- |
| **ALLERGIES:** Please list any allergies you have: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION**:are you taking any regular / repeat medication? If so please make a list below OR attach the most recent repeat prescription list from your previous GP surgery. This information is essential to enable your new GP to authorise future repeat medication. | | | |
|  | | | |
| **PHARMACY :** The Practice uses Electronic Prescribing, please state which Pharmacy you would like your prescription sent to. | | | |
| Topsham Pharmacy  Tesco Pharmacy (please state which store)  Any other Pharmacy (please state) | Glasshouse Pharmacy  Boots Pharmacy (please state which store) | | |
|  | | | |
| **Are you 25 or under?** | |  | |
| Would you like a free chlamydia test? | | **YES** | **NO** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FOR FEMALES AGED 15 TO 65 - if you use any form of contraception please circle which one.** | | | | | |
| Coil | Depot injection | Implant | Oral Pill | Patches | Other………………………………………………. |
| If you do use contraception, when was your last check-up / review with GP or Nurse? | | | | | Date: |
| If you have a Coil or Implant approximately what date was it fitted? | | | | | Date: |
| If you have depot injections when was your last one? | | | | | Date: |
| Have you had a recent smear? | | | | | Date: |
| Have you had a recent mammogram? | | | | | Date : |

**YOUR LIFESTYLE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EXERCISE: Please **circle** which of these terms best describes how much exercise you take on a regular basis. | | | | |
| None | Light | Moderate | Heavy | |
| Body Measurements | Height | Weight | | Waist Circumference |
|  |  | |  |

**YOUR DIET**

|  |  |
| --- | --- |
| Do you have a special diet? | If so, please state |
| Do you add salt to your food after cooking | YES/NO |
| Do you have a varied diet including milk, vegetables and fruit? | YEs/NO |
| Has your Cholesterol been checked in the last 2 years? | YES/NO If yes what was it? |

**YOUR SMOKING STATUS** (Please tick boxes and complete with information as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| Never Smoked |  | N/A |  |
| Ex- Smoker |  | Date Stopped? |  |
| Cigarette Smoker |  | How many per day? |  |
| Roll Own Cigarettes |  | How many per day? |  |
| Cigar Smoker |  | How many per day? |  |
| Pipe Smoker |  | How many ounces per week? |  |

**If you would like to stop smoking our trained advisors can help you. Please ask for details.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **YOUR ALCOHOL CONSUMPTION** | SCORE 0 | SCORE 1 | | SCORE 2 | SCORE 3 | | SCORE 4 | | YOUR SCORE |
| 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), Monthly (1) or Less than Monthly (2).**  **Stop here is the answer is Weekly (3) or Daily (4).** | | | | | | | | | |
| How often during the last year have you failed to di 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 Professional been concerned about your drinking or suggested that you cut down? | No |  | Yes but not in the last year | |  | Yes during the last year | | |  |
| TOTAL SCORE | |  | |

**If you total is 3 or more please complete the 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 Professional 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**

Would you like any help reducing your alcohol consumption? If yes, please book an appointment to see a GP.

**ARE YOU A CARER?**

A Carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

**If Yes, please complete this section.**

|  |  |
| --- | --- |
| **Details of the person(s) you are caring for** | |
| Full Name |  |
| DOB |  |
| Address including Post Code |  |
| Telephone No. |  |
| Relationship to you |  |
| Is the person you care for registered at Topsham Surgery? | YES/NO |

**If you are being Cared for** PLEASE COMPLETE THIS SECTION

|  |  |
| --- | --- |
| **Details of your carer** | |
| Full Name: |  |
| DOB |  |
| Address including Post Code |  |
| Telephone No. |  |
| Relationship to you |  |
| Is the person you cares for you registered at Topsham Surgery? | YES/NO |

If you would like support please Devon County Council Carer Support Services on 03456-434435 or visit their website www.devoncarers.org.uk

If you consent to your Carer being informed of any medical information about you, which is held by the Surgery, please sign and date below; if NOT leave blank

Signed: ……………………………………………………………….. Date: ……………………………

**NHS ORGAN DONOR REGISTRATION**

If you want to register your details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after death. Please circle all that apply and sign this box.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Kidneys | Heart | Liver | Pancreas | Corneas | Lungs | Any of my organs & tissue YES/NO | | |
| Signature confirming my agreement to organ/tissue donation: | | | | |  | | Date: |  |

**NHS BLOOD DONOR REGISTRATION**

Would like to join the NHS Blood Donor Register? Please sign below to say that you would be prepared to donate blood.

|  |  |  |
| --- | --- | --- |
| Signature confirming consent to inclusion on the NHS Blood Donor Register : | |  |
| Date: |  | |

**TEXT MESSAGING AND EMAIL CONSENT**

Topsham Surgery sends a text confirmation of appointments made and a further text reminder 24 hours before your appointment. If we have details of your mobile telephone number, these messages will be sent to your mobile. The Surgery will not pass your personal information onto any third party. By signing this form you are agreeing to the Surgery contacting you in this way but if you do not wish to receive these texts please let us know.

**CHANGE OF DETAILS**

|  |
| --- |
| I understand that it is my responsibility to inform Topsham Surgery should my phone number, email or any other personal details change. |

|  |  |
| --- | --- |
| SIGNATURE OF PATIENT : |  |
| OR SIGNATURE on behalf of a patient: |  |
| DATE: |  |

|  |  |
| --- | --- |
| **Office use only** | |
| **Proof of residency /ID checked by……………………………………………… Date ………………….** | |
| □ Passport | □ Birth Certificate |
| □ Driving Licence | □ Proof of Address / Utility Bill |
| □ Work / Study Permit | □ Update Nominated Pharmacy |
| □ Donor Form Signed | **Signature of member of staff**  **Allocated GP (XacWQ)**  **Patient Informed of named GP (Xab9D)** |

|  |  |  |
| --- | --- | --- |
| SCR-logo.png |  | **Devon Col** |
|  |
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|  |
|  |

Your Name:

Date of Birth:

NHS Number (if known):

**Topsham Surgery** offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

**What is the NHS Summary Care Record?**

The Summary Care Record contains basic information about:

* **any** **allergies you may have,**
* **unexpected reactions to medications, and**
* **any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and ‘Out of Hours’ health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if Healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, Health Professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree (explicit consent).

**Children under the age of 16**

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP Surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the Surgery for additional forms if you want to opt them out.**

* If you are **happy** for a Summary Care Record to be set up for you then you need **take no further action.**
* If you want to **opt-out** now please **tick the box below** **and sign** and return it to Reception as soon as possible.

**Please tick the box and sign below if you do not want a Summary Care Record:**

**No** I do not want a Summary Care Record

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_