Patient informed of Registered GP
Name of Registered GP

NEW PATIENT REGISTRATION

Please complete in **BLOCK** Capitals with as much information as possible.

TITLE	MR	MRS	MISS	MS	MALE	FEMALE
SURNAME						
FIRST NAME			MIDDLE NAME			
ANY PREVIOUS NAMES						
TOWN AND COUNTRY OF BIRTH						
NHS NUMBER (if known)						
DATE OF BIRTH						
HOME ADDRESS POSTCODE						
DISPENSING STATUS ***(OFFICE USE ONLY)***						
HOME TELEPHONE						
MOBILE TELEPHONE						
Is the telephone number above owned by the patient being registered?	YES	NO				
It is the responsibility of the registered patient to keep your details up to date. Patients over the age of 12 are legally entitled to have their own number registered.						
Do you consent for the practice to contact you by SMS text message?	YES	NO				
Email address						
Do you consent for the practice to contact you via email	YES	NO				
The following information is required to allow us to trace your medical records.						
IF YOU HAVE MOVED FROM OVERSEAS – THE DATE YOU BECAME A UK RESIDENT						
PREVIOUS ADDRESS IN UK POSTCODE						
NAME AND ADDRESS OF PREVIOUS GP						

If you are returning from the Armed Forces		
ADDRESS BEFORE ENLISTING POSTCODE	Enlistment Date	Discharge Date
About you		
MAIN LANGUAGE SPOKEN		
ENGLISH SPEAKER	YES	NO
WOULD YOU LIKE A NEW PATIENT HEALTH CHECK	YES	NO
IF YOU HAVE ANY KNOWN		

Rec Ints		Date	

March 2017

ALLERGIES PLEASE PROVIDE DETAILS			
SMOKING STATUS	NON SMOKER	NO LONGER A SMOKER	SMOKER – HOW MANY PER DAY?
WOULD YOU LIKE HELP TO STOP SMOKING	YES		NO
YOUR HEIGHT			
YOUR WEIGHT			
ARE YOU A CARER?	YES		NO
DO YOU HAVE A CARER?	YES		NO
PLEASE PROVIDE THE PRACTICE WITH ANY FURTHER INFORMATION YOU FEEL WILL BENEFIT YOUR CARE			

NHS Sharing: Please make your choice below

Choice One – NHS Summary Care Record (SCR)

This is your own choice about how you would like to share your health record:

I would like my health record at Sleaford Medical Group to be available for other healthcare services providing care for me to view with my full consent	**YES**	**NO**

Choice Two – Enhanced Data Sharing Module (EDSM)

SHARING OUT: I would like my health record at Sleaford Medical Group to be available for other healthcare services providing care for me to view with my full consent	**YES**	**NO**
SHARING IN: I would like Sleaford Medical Group to be able to view the information in my health record that has been recorded by other services	**YES**	**NO**

Please Note: You may change your preference at any time by completing Consent for Record Sharing form.

Name:_____

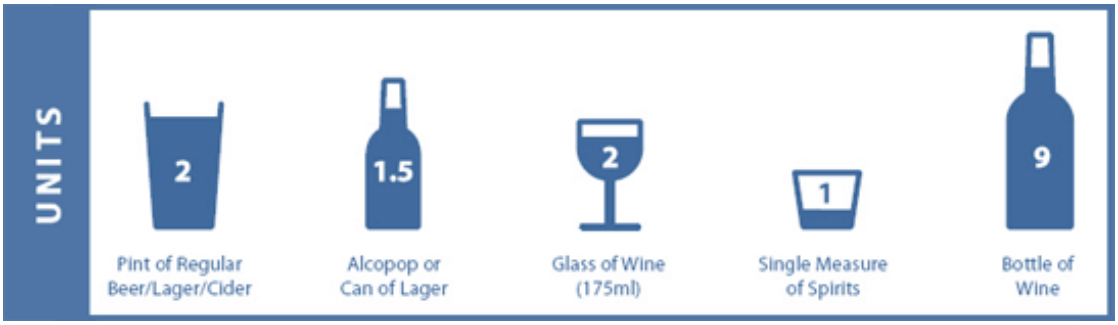
Signature: _____Date:_____

Online Access: You may have online access by attending the surgery with current identification

ALCOHOL QUESTIONNAIRE

For the following questions please circle the answer which best applies to your drinking in the last year.

Declined to complete Alcohol screening test questionnaire. ☐



1.	**MEN:** How often do you have 8 or more drinks on one occasion? **WOMEN:** How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
2.	How often during the last year have you not been able to remember the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
3.	How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
4.	Has a relative, friend, Doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, during the last year	-	-
5.	How often do you have a drink that contains alcohol?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
6.	How many standard alcoholic drinks do you have on a typical day when you are drinking? (please circle)	1-2	3-4	5-6	7-8	10+
7.	How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
8.	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
9.	*See question 3*					
10.	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
11.	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily
12.	*See question 2*					
13.	Have you or someone else been injured as a result of drinking?	No	Yes, but not in the last year	Yes, during the last year	-	-
14.	*See question 4*					

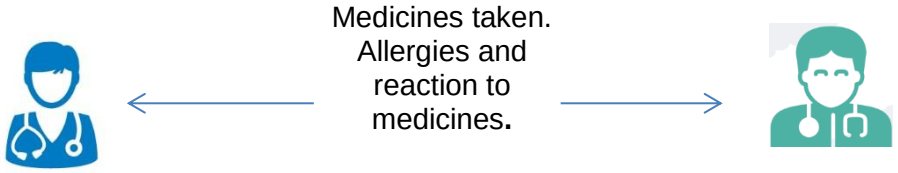
Your Choice-Your Record

With so many choices to make about sharing your information how can you be sure you are making the correct choices for you and your dependents?

This leaflet aims to explain the differences between the options available, ensuring you can make a considered, informed choice. We have also included the relevant consent/dissent forms, please read these carefully before your preference and returning them to the Reception.

Choice 1 - NHS Summary Care Record (SCR) - A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had, no other medical information is held in the record. Having this information stored in one place makes it easier for healthcare staff will have access to this record.

Example: You have a fall and are unconscious, an ambulance is called to take you to hospital; there is nobody with you that knows your medical history. When you get to the hospital the Doctor decides you need some medicine, how does he know if the one he is about to give you will cause an allergic reaction? If you have said YES to share your record the Doctor will have instant access to this information and will be able to treat you accordingly. If you say NO this could delay treatment whilst this information is requested from your GP.



Choice 2 – Enhanced Data Sharing Module (EDSM) - The clinical computer system used at Sleaford Medical Group is System One. This system is widely used in this area and across England. The system gives us a facility (EDSM) to share your health record with other health providers involved in your care. Your health record includes your medical history, medication history and any allergies you may have. You can now choose whether to share these full medical details with other health provider units (for example the District Nurses). Many organisations may use System One including some GP practices, out of hour's services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.
You have two choices which allow you to control how your record is shared. You can change these choices at any time by completing a consent form.

Sharing OUT: This controls whether your information recorded at this practice can be shared with other health care providers.

Sharing IN: This determines whether or not this practice can view information in your record that has been entered by other services who are providing care for you or who may provide care for you in the future.

Example: Imagine you are receiving care from your GP, a district nurse and a smoking clinic. You want your GP and district nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However, you don't want the smoking clinic to see any of your other medical information.

CONSENT TO SHARE – RESTRICTED ACCESS

Patients Details (The person whose records another individual is to be granted access)	
Surname	
First Name	
Date of Birth	
NHS Number	
Male/Female	
Address Postcode	
Contact Telephone Number	
Details of the person who will have restricted access	
Full Name	
Address Postcode	
Contact Telephone Number	

Please Note: Identification will need to be provided by the patient upon application. Sleaford Medical Group must be able to verify consent and signature from the patient.

Give consent to the person named above to act on my behalf for: (Please Tick)	**YES**	**NO**
Collect Blood/Urine/X-Ray Request Forms & Results		
Collect Sick Notes		
Collect Prescriptions from Reception		
Discuss my continuing medical care with my GP		

Signed: _____ Dated: _____

ID Check_____

This will remain on your records unless you notify the surgery that you wish for it to be removed.