Barbourne Health Centre

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Please complete this confidential questionnaire

Please be advised that we need proof of ID (i.e.: passport or driving license) and proof of address before we can accept your registration. If you haven't got all this with you, then please take the forms away and bring back together with all the relevant paperwork.

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

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

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

Title (Mr/Mrs/Miss/Ms/Other)	
Full name	
Address and Postcode	
Date of Birth	
Gender	
Any Previous surnames?	
NHS Number if known	
Landline Telephone Number	
Mobile Number: **Do you give consent for us to contact you via txt?**	
Work Number:	
Email Address: **Do you give consent for us to contact you via email?**	
Town and Country of Birth	
Marital status	
Names and Ages of Children	
Other residents in your home	

Next of Kin, Relationship to patient & contact telephone number	
If applicable, date you first came to live in Britain.	
Previous Home address & postcode	
Previous Doctors surgery name & address	
Are you returning from the Armed Forces?	

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 /Sylheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If you are a current smoker, how many do you smoke a day?					

If you wish to stop smoking and need help and advice please visit www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit

How often do you exercise?	**No. times per week**	**Type(s) of exercise:**	

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Your Medical Background:					
What illnesses have you had & When?					
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?**		
Do you have any medical problems at present?					
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)					
Have you a nominated pharmacy?	Please note we will need to amend your records as they transfer over if you need to alter this location from your previous pharmacy. PHARMACY YOU WISH TO COLLECT YOUR PRESCRIPTIONS FROM NOW ON:				

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 Health Centre for contraceptive services?			**Yes**	**NO**

Specific Needs: **Please detail below any specific needs you have so the Health Centre 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 Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	

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:**	
Have you ever had a social worker or received additional help from the early help hub	**Yes/No**	
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 New Patient 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:**

Patient Participation Group

The Health Centre 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 Health Centre.
If you are interested in getting involved, please tick the box below and we will arrange for the Health Centre Patient Participation Group Application Form to be sent to you.

Yes, I am interested in becoming involved in the Health Centre Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Access through Emis Web

Patient Access lets you use the online service of our practice. This includes arranging appointments, repeat medication, secure messages, viewing parts of your medical records and updating your details.

If you wish to sign up please see reception with proof of ID and we shall print you off all the relevant passwords and paperwork for you to set it up at home.
There is also an app available to download on android and iOS mobile phones.

Patient Signature:		**Signature on behalf of Patient:**	
Date			

Information for new patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

c) **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of Patient: ……

Address: ……

Postcode: …… Date of Birth: ……

NHS Number (if known): ……

Signature: …… Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

Alcohol use disorders identification test consumption (AUDIT C)

This alcohol harm assessment tool consists of the consumption questions from the fullalcohol use disorders identification test (AUDIT).

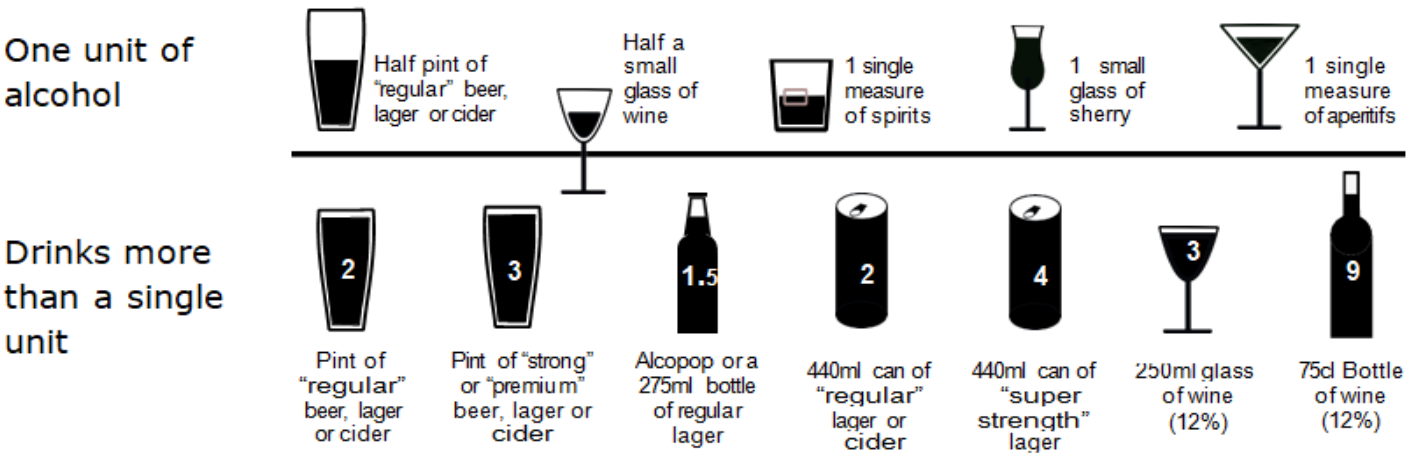
Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
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	

AUDIT C score	

What to do next

If you have a score of 5 or more and time permits, complete the remaining alcohol harm questions on the next page to obtain a full AUDIT score

Alcohol unit reference



Remaining AUDIT assessment 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 youhad started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed todo 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 neededan alcoholic drink in the morning to get yourselfgoing after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had afeeling 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 aresult 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 orsuggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

AUDIT C score	