



Doctors: O’Flanagan, Smith, Rashid, Atxa and Nair

Saltscar Surgery • 22 Kirkleatham St. • Redcar • TS10 1UA
Tel: (01642) 471388 • Fax: (01642) 488701
Web: www.saltscarsurgery.nhs.uk

Form:
ADULT

ADULT Registration Questionnaire

Failure to complete in full may result in non-registration.

Today’s Date: _____ Date of birth _____ (dd/mm/yyyy)
Forenames: _____ Surname: _____
Address: _____

Postcode: _____
Telephone: (must complete) _____ Mobile: _____

Do you consent to receive:

SMS/Text reminders of appointments? *Please tick one:* YES NO
Email messages: *Please tick one:* YES NO
Automated voice messages *Please tick one:* YES NO

Next Of Kin Details:

Full Name: _____
Relationship : _____ (i.e mother/father/spouse)
Address: _____
Telephone: _____ Mobile: _____

Do you have a Carer? *please tick one* YES NO (If so please give details)
Name: _____
Address: _____
Telephone: _____ Mobile: _____

Are you the carer for somebody else? YES NO (If YES please give details)
Name: _____
Address: _____
Telephone: _____ Mobile: _____

Communication:

Do you have any special communication needs due to a disability or sensory loss? For example do you need information in Braille or use British Sign Language to communicate. *Please tell us below:*



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IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORDS

Please read and choose one of the three options. Ask for help from staff if you are not sure.

Do you give permission for the surgery to share your child's information with other Healthcare Providers when you visit them to be seen or if you are admitted to A&E in an emergency?

For more information please read the attached leaflet *Your Electronic Health Record*

Please choose and sign just ONE option below:

NOTE: If you choose not to specify a preference, the records will be shared on the grounds of good medical practice.

<p><u>Option 1</u></p> <p>After reading the above leaflet I am happy for my full patient record to be viewed by health and care organisations involved in my care without an extra verification step.</p> <p>Signature: _____ Date: _____</p>
<p><u>Option 2</u></p> <p>After reading the above leaflet I DO NOT want my patient data to be viewed by other health and care organisations involved in my care.</p> <p>Signature: _____ Date: _____</p>
<p><u>Option 3</u></p> <p>I would like to provide an extra security code, or online approval to health and care organisations involved in my care in order to view my record.</p> <p>For this step to work, you must keep your mobile number and email address up to date or have access to your GP online account.</p> <p>Signature: _____ Date: _____</p>

Shared Information options counter-signed by staff:

Signature: _____ Date: _____



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Ethnic Origin: Please Tick One:

White British	
White Irish	
Other White Background	
Black Or Black British Caribbean	
Black Or Black British African	
Other Black Background	
Asian or Asian British Indian	
Asian or Asian British Pakistani	
Asian or Asian Bangladeshi	
Asian or Asian Chinese	
Other Asian Background	
Mixed White and Black Caribbean	
Mixed White and Black African	
Mixed White and Asian	
Other Mixed Background	
Other Ethnic Background	

Main Language Spoken: _____ 2nd Language: _____

Basic Health: Height: _____ Weight: _____

Do you suffer from any medical condition?

E.g. Heart disease, high/low blood pressure, Diabetes, Asthma, Arthritis etc.

Have you had any operations or investigations? If so please give approximate dates and details.

Approx. date Investigation or operation

_____	_____
_____	_____
_____	_____
_____	_____

Are you currently under the care of the hospital? If so please give details:

PLEASE REMEMBER TO CONTACT THE HOSPITAL TO INFORM THEM OF YOUR NEW GP.



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Current medications

Please list the names and dosage of your current medication (if any)

<i>Name of medication</i>	<i>Dosage</i>	<i>Name of medication</i>	<i>Dosage</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Important Notice: If you are taking any of these medications:

- Codeine, Diazepam, Gabapentin, Pregabalin,
- Temazepam, Tramadol, Zolpidem, Zopiclone

(or drugs similar to these) by agreeing to be registered at this surgery, you are agreeing to enter any reduction programme the doctor deems necessary.

Do you have any allergies, if so please give details:

Has your mother, father, brother or sister suffered from any of the following?

Please **circle** yes or no.

Heart disease below the age of 60	YES / NO	Stroke	YES / NO
High blood pressure	YES / NO	Asthma	YES / NO
Diabetes	YES / NO	Glaucoma	YES / NO

What is your present occupation? _____

(If retired, please state your former occupation)

Have you any other medical or social concerns of which you might wish us to be aware of?

What is your current smoking status?

I have never smoked I'm an ex-smoker and quit about _____ ago

I'm a smoker I smoke about _____ a day

Alcohol audit:



UNITS

2
Pint of Regular Beer/Lager/Cider

1.5
Alcopop or Can of Lager

2
Glass of Wine (175ml)

1
Single Measure of Spirits

9
Bottle of Wine

IN THE LAST YEAR - please circle the appropriate answer boxes:

1. *Men:* How often do you have EIGHT or more UNITS on one occasion?
Women: How often do you have SIX or more UNITS on one occasion?

Never	less than monthly	monthly	weekly	daily or almost daily
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2. 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
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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 or almost daily
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4. In the last year has a relative or friend, or a doctor or health worker been concerned about your drinking or suggested you cut down?

No	Yes, on one occasion	Yes, more than once
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Application for online access to appointments, repeat prescriptions

Surname	
First Name	
Date of Birth	
Address	
Email address	
Telephone Number	
Mobile phone number	

*I wish to have access to online services for booking appointments and ordering my repeat prescriptions **

Signature	Date
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***If you wish to have full online access or read coded access, please ask reception for the alternative application form.**

For Practice Use Only

Identity Verified by (Staff Member's Full name)	Date	Method Photo ID which includes proof of Address <input type="checkbox"/> Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>
State ID Seen		
Account authorised by		
Date account created		
Date passphrase sent & method sent to patient		
Further notes		



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Summary Care Record

The new NHS Summary Care Record is being 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 will contain 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 Accident and Emergency 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.

If you choose not have to have a Summary Care Record, (although you are strongly recommended to do so), at any time in the future you may change your mind. All you need do is write to the Surgery informing them of your decision to “Opt-In”.

Please tick ONE box: I would like to have a Summary Care Record YES NO

More information can be found at
<https://www.nhs.uk/using-the-nhs/about-the-nhs/your-health-records/>

Thank you for taking the time to complete our new patient questionnaire.

We may invite you to take a new patient health check.

<i>For office use only – Admin clerk to confirm each entry is checked and coded</i>		
<input type="checkbox"/> SMS	<input type="checkbox"/> Record sharing	<input type="checkbox"/> NoK
<input type="checkbox"/> M-jog	<input type="checkbox"/> Med Hist & Ethnicity	<input type="checkbox"/> Recoded
<input type="checkbox"/> SI / SMS Consent	<input type="checkbox"/> SCR	<input type="checkbox"/> Tasked to clinician
<input type="checkbox"/> Online access verified	<input type="checkbox"/> Login issued	
Input by: _____	Date: _____	