|  |  |  |
| --- | --- | --- |
| **Name:** | **DoB:** | **Date:** |

**The practice needs your express consent to use your data to help manage your care. The practice strongly recommends that you sign sections 1, 2 and 3 which will ensure you continue to receive the highest quality of health care.**

**\*Data Sharing**

|  |
| --- |
| **1. Summary Care Record (SCR)**The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information, which includes: current medication, any allergies and any bad reactions to medication.**Please sign if you wish to opt-in of the Summary Care Record.** Signature: …………………………………………… |
| **2. Enhanced Summary Care Record** This is the same as above where other important information can be shared i.e. Any health issues, illnesses, operations, vaccinations, next of kin or what support you may need. Expressed consent given Signature: ……………………………………………  **Please sign if you wish to opt-in of the Enhanced Summary Care Record (**XaXbZ)   |

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| **3. Risk Stratification Preferences****Risk stratification** is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Risk Stratification programme allows uploading of patient’s identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data. **Please sign if you wish to opt-in of the Risk Stratification programme .** Signature: ……………………………………………… (XabjB)**For more information please visit our website at**  [**https://www.thegrobysurgery.nhs.uk/**](%20https%3A//www.thegrobysurgery.nhs.uk/) |

**The practice has no particular view as to whether you should consider sections 4 and 5**.

|  |
| --- |
| **4. Care Data**Care data is anonymised data used by the Health Service and other agencies to plan care for population. Data of this type is used primarily for planning purposes. Further information is on our website (https://www.thegrobysurgery.nhs.uk/). Care Data information leaflets are available on the NHS England website ([www.england.nhs.uk/ourworks/tsd/care.data/](http://www.england.nhs.uk/ourworks/tsd/care.data/)). Patients who agree have their information automatically extracted from their patient record by the Health & Social Care Information Centre. **Please sign if you wish to opt-out of the Data Care Information.** Signature: ………………………………………… (XaZ89) |

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| **5. Medical Interoperability Gateway (MIG)**Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.**For more information please visit the “Further Information” page on our website at:** https://www.thegrobysurgery.nhs.uk/**Please sign if you wish to opt-in of the Medical Interoperability Gateway .** Signature: …………………………………………………….. |

Groby Surgery – Adult Registration Form

Thank you for applying to join The Groby Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all the questions but what you do fill in will help us give you the best possible care. **You must supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and a second proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

**Fields marked with an asterix (\*) are mandatory.**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First & other names |
| \*Any previous surname(s) (if applicable) |  | \*Date of Birth |
| \*[ ] Male [ ] Female |  | NHS No. [ ] [ ] [ ]  [ ] [ ] [ ]  [ ] [ ] [ ] [ ]  |
| Town and Country of birth: |  | \*Home addressand \*Postcode: |
| KEYSAFE (If you have one) |
| Calling Name: |  | Email address: |
| Marital Status:[ ]  Married [ ]  Single [ ]  Divorced [ ] Widowed |  | \*Home telephone No. |
| Alternative telephone No. e.g. Work(Please state) |
| Occupation:[ ]  Employed [ ]  Self Employed [ ]  Retired[ ]  Unemployed |  |  |
| **\*Mobile No.** As a practice we will send text messages where appropriate, if you wish NOT to receive texts [ ] No |

|  |  |  |
| --- | --- | --- |
| If you are from abroad please tell us the date you first came to live in the UK: If previously resident in UK, date of leaving:  |  | Have you ever been in the employ of the Armed Forces? [ ]  Yes [ ]  No Date Enlisted: Date Left: (Ua0T3) |

**\*Additional details about you**

|  |
| --- |
| \*What is your ethnic group?Previous G.P./ Surgery:**White** [ ]  British [ ]  Irish [ ]  Other White (please specify):**Black** [ ]  Caribbean [ ]  African [ ]  Other Black (please specify):**Asian** [ ]  Indian [ ]  Pakistani [ ]  Other Asian (please specify):**Mixed** [ ]  White & Black Caribbean [ ]  White & African [ ]  White & Asian |
| If your preferred spoken language is NOT English please indicate what it is |

**Next of kin/Emergency Contact**

|  |  |  |
| --- | --- | --- |
| Name |  | Relationship to you |

|  |  |  |
| --- | --- | --- |
| Next of kin/Emergency telephone number(s) |  | Next of kin address (if different to above) |

 **Looked after Children**

|  |
| --- |
| Are you looking after someone else’s child? [ ]  Yes [ ]  NoIf Yes, under what arrangements:[ ]  Section 20-Voluntary Care [ ]  Interim Care Order [ ]  Care Order [ ]  Child arrangement order/Residence Order [ ]  Special Guardianship order [ ]  Placed for adoption[ ]  Private arrangement/Private Fostering/informal arrangement(please note you have a duty to notify social care of this arrangement) |

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**A ‘carer’ is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.**

|  |
| --- |
| Do you have a Carer? [ ] Yes [ ] No Name & Relationship: **Their contact details**:Do you consent for your carer to be informed about your medical care? [ ] Yes [ ] No ( 918F) |

|  |
| --- |
| Are you a Carer? [ ] Yes [ ]  No (Ub1ju)If yes, do you look after someone who is a patient of The Glenfield Surgery? [ ] Yes [ ] No [ ]  Don’t knowIf yes, what is their name?   Are they a: [ ] Relative [ ] Friend [ ] Neighbour [ ]  Other (please specify)Do you have Power of Attorney for this Person? [ ] Yes [ ] No |

**\*Medical details**

**Have you ever had any of the following conditions?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Epilepsy** | [ ]  Yes  |  | **Rheumatoid Arthritis** | [ ]  Yes  |
| **High Blood Pressure** | [ ]  Yes  |  | **Mental Illness**  | [ ]  Yes  |
| **Heart Attack** | [ ]  Yes  |  | **Diabetes (type 1 or type 2)** | [ ]  Yes  |
| **Angina (stable / unstable)** | [ ]  Yes  |  | **Asthma** | [ ]  Yes  |
| **Stroke** | [ ]  Yes  |  | **COPD (or Emphysema)** | [ ]  Yes  |
| **Transient Ischaemic Attack** | [ ]  Yes  |  | **Osteoporosis / Bone Fractures** | [ ]  Yes  |
| **Cancer** | [ ]  Yes  |  | **Peripheral Vascular Disease** | [ ]  Yes  |
| **Hypothyroidism** | [ ]  Yes |  | **Depression** | [ ]  Yes  |

|  |
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| Do you have any special needs regarding information or communication,(E.g. Deaf or visual impairment) please give details. |
| Do you communicate using BSL/deafblind manual/other: |
| Do you communicate using hearing aids / talking mat/other: |
| Do you need information in large print / braille/other: |
| If we need to contact you which would be the best way is text/ phone/ letter/ other |

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| List any serious illnesses / operations / accidents (women: any pregnancy related problems) & the year they took place: |
| Do you have any disabilities (whether you are registered disabled or not) |
| Physical Disability – Please describe: | Learning Disability – Please describe: |

**Do you have a family history of any of the conditions below?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **High Blood Pressure** | [ ]  Yes  | Who |  | **DVT / Pulmonary Embolism** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged >60 yrs | [ ]  Yes  | Who |  | **Breast Cancer** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged <60 yrs | [ ]  Yes  | Who |  | **Any Cancer**Specify type: | [ ]  Yes  | Who |
| **Raised Cholesterol** | [ ]  Yes  | Who |  | **Thyroid disorder** | [ ]  Yes  | Who |
| **Stroke / CVA** | [ ]  Yes  | Who |  | **Epilepsy** | [ ]  Yes  | Who |
| **Asthma** | [ ]  Yes  | Who |  | **Osteoporosis** | [ ]  Yes  | Who |

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|  |  |  |
| --- | --- | --- |
| \*Height ft/m in/cm |  | (**for women only**) Have you had a cervical smear?[ ] Yes [ ] No (*Please state where, when and the result if possible*)[ ]  Yes [ ]  No Have you had a hysterectomy |
| \*Weight st/kg lb/g |

|  |  |
| --- | --- |
| Do you smoke? Yes [ ]  No [ ]  Never [ ]  If Yes, what do you primarily smoke: **(please circle)** Cigarettes / Cigar / Pipe How many do you smoke a day? | The best way of stopping smoking is with a combination of medication and support. For details of ‘Smoking Cessation’ clinics please call 03456466666. |
|  |
| Are you an ex-smoker [ ]  Yes [ ]  No How many did you used to smoke a day? When did you quit?  |

|  |  |
| --- | --- |
| **Alcohol Consumption Questions** (please circle your answers in the boxes below)  | **Unit scoring system** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 timesPer 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 – 9 | 10+ |
| 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 |
| **If you score 5 or more on the above please complete the questionnaire below -** Above score [ ]   |
| **Scoring: 0-7= sensible drinking, 8-15= hazardous drinking, 16-19=harmful drinking, 20+ possible dependence.**

|  |  |  |
| --- | --- | --- |
|  **Questions**  | **Scoring System** 0 **1 2 3 4** | **Your score** |
| How often do you have a drink that contains alcohol? | **Never** | **Monthly or less** | **2-4 times per month** | **2-3 times per week** | **4+ times per week** |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | **1-2** | **3-4** | **5-6** | **7-9** | **10+** |  |
| How often do you have 6 or more standard drinks on one occasion? | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| 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 or almost daily** |  |
| How often in the last year have you failed to do what was expected of you because of drinking? | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| 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 or almost daily** |  |
| How often in the last year have you had a feeling of guilt or regret after drinking? | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| How often in the last year have you not been able to remember what happened when drinking the night before? | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down? | **No** |  | **Yes but not in the last year** |  | **Yes during the last year** |  |

 **TOTAL** |

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|  |
| --- |
| **Repeat Medication Information –** Please attach a repeat prescription request form from your previous G.P. if you have one. |
| **Name of Medication** | **Strength (mg)** | **How Often Medication is taken** |
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| \*Are you allergic to any medicines? [ ]  Yes [ ]  No (if yes please specify) |
| \*List other allergies (pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of)  |

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| **Please record any additional information about you that you think is important for us to know** |

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**New Patient Health-check**

…As part of our Practice policy we are offering a New Patient health-check with a Health Care Assistant to anyone aged between 40 and 75. If you should like to take this up please contact reception to make an appointment for a ‘Registration Health check’.

If you would like to nominate a local pharmacy, please indicate below.

Glenfield Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_ Well, Groby : \_\_\_\_\_\_\_\_\_\_\_\_\_ Masons, Ratby: \_\_\_\_\_\_\_\_\_\_\_

Mornigside Pharmacy: \_\_\_\_\_\_\_\_\_\_\_ Well, Anstey: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parkem Pharmacy: \_\_\_\_\_\_\_\_\_\_ Village Pharmacy, Kirby Muxloe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Access**

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| **On-line Services**Once your application to join our practice has been accepted you’ll be able to register with our on-line service provider (SYSTMONE) and access appointments, prescriptions and view certain aspects of your medical records (DCR) via the internet. This service is known as **Patient Access**.***All of the details that you need for this are available on our practice website at*** … <https://www.thegrobysurgery.nhs.uk/> ***or PLEASE SEE ATTACHED FORM TO REGISTER.***This service is available to everyone with a valid email address.***We can only accept your request for Patient Access if your email address is valid and not shared by another person.*** |

We aim to have patient’s registered within 2-3 working days or less but, due to practice workloads this may take a few days longer.

If there are any problems with your registration we’ll contact you to clarify any issues.

|  |  |  |
| --- | --- | --- |
| **Print Name****\*Sign** |  | **\*Date**  |

|  |  |
| --- | --- |
| **Signed on behalf of patient** (*if applicable*)(e.g. adults lacking capacity) |  |
| Relationship to Patient: |  |

|  |
| --- |
| **FOR OFFICE USE ONLY** |
| **PHOTO ID [ ]  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **ADDRESS ID [ ]  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Staff Name:…………………………………………………………… Date Accepted: ………………………………….** **Checked by …………………………………………………………... Date ……………………………………** |

Reg form June 22.