Highcroft Surgery

REGISTRATION FORM

Please complete all sections of the form by writing clearly or by ticking the appropriate boxes. Incomplete or unclear forms may delay your registration. Separate forms must be completed for each member of your household who you wish to register.

Personal details

Full Name _____ Date of birth ___ / ___ / _____

Home telephone number _____ Email address _____

Mobile number _____ Work telephone _____

We offer a text messaging service. You will be sent reminders for your appointments and we may text you about other health matters. Please tick here if you would NOT like to receive text messages. ☐

Preferred contact number: Mobile ☐ Home ☐ Work ☐ Alternate ☐ _____

Preferred contact method: Phone call ☐ Text Message ☐ Email ☐ Post ☐

Have you served in the armed forces? Yes ☐ No ☐

Do you currently live in a Residential or Nursing home? Residential ☐ Nursing ☐ Neither ☐

Emergency Contact

In case of emergency please provide us with the details of an emergency contact if you would like us toS contact someone on your behalf. We will only contact them in an emergency e.g. hospital admission.

Emergency contact name _____ Date of birth ___ / ___ / _____

Relationship _____ Contact number _____

Carers

Do you regularly provide care to a relative, friend or neighbour helping them to live at home?

Yes ☐ No ☐

Do you have someone who regularly cares for you to enable you to live at home?

Yes ☐ No ☐

If yes, are they: Paid ☐ Relative ☐ Friend/Neighbour ☐

Name: _____ Date of birth: _____

Contact number: _____

Address: _____

What is your ethnic group?

Choose one option that best describes your ethnic group or background _____

White

1. English / Welsh / Scottish / Northern Irish / British
2. Irish
3. Gypsy or Irish Traveller
4. Any other white background

Mixed / Multiple ethnic groups

5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Any other Mixed / Multiple ethnic background

Asian / Asian British

9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background

Black / African / Caribbean / Black British

14. African
15. Caribbean
16. Any other Black / African / Caribbean background

Other ethnic group

17. Arab
18. Any other ethnic group

19. Prefer not to say

Is English your first language? Yes ☐ No ☐

If "no", do you require an interpreter? Yes ☐ No ☐

Allergies

Animal Hair	☐	Fruit	☐	Penicillin	☐
Cow's Milk	☐	Hayfever	☐	Shellfish	☐
Egg	☐	Nuts	☐	Other _____	☐

Family medical history

Asthma	☐	Heart Attack	☐	Thyroid Disorder	☐
Bowel Cancer	☐	Heart Attack before 60	☐	Other (please specify)	☐
Breast Cancer	☐	High blood pressure	☐	_____	
Diabetes	☐	Stroke / CVA / TIA	☐	_____	

Significant health problems

Atrial fibrillation	☐	Diabetes	☐	Impaired vision	☐
Absent spleen	☐	Epilepsy	☐	Wear glasses	☐
Asthma	☐	High blood pressure	☐	Other (please specify)	☐
COPD	☐	Hypothyroidism	☐	_____	
Coronary heart disease	☐	Stroke / CVA / TIA	☐	_____	
Current kidney disorders	☐	Impaired hearing	☐	_____	
Depression	☐	Wear hearing aid	☐	_____	

Smoking status

Do you smoke? Yes ☐ No ☐ If Yes, how many a day? _____

Have you ever smoked? Yes ☐ No ☐

If Yes, how many a day? _____ How long since stopping? ___ Years

If you would like help to stop smoking you can call 08000 2465345, text QUIT to 66777, or go to www.smokefreelifenottinghamshire.co.uk.

Alcohol consumption – FAST Alcohol Screening test (FAST)

Please circle the answer that applies best

1 *Men*: How often do you have eight or more drinks on one occasion?
Women: How often do you have six or more drinks on one occasion?
(1 drink = ½ pint of beer OR 1 glass of wine OR 1 single spirit)

Never Less than monthly Monthly Weekly Daily or almost daily

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

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

4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

Repeat medication – please list any repeat medication you take regularly

Medication *e.g. Paracetamol tablets*	Strength *e.g. 500mg*	Medication *e.g. Paracetamol tablets*	Strength *e.g. 500mg*
1		6	
2		7	
3		8	
4		9	
5		10	

Electronic Prescriptions Service (EPS)

If you have medication on repeat it can be really helpful for us and you to have your prescriptions sent to a pharmacy electronically. You still order your medication in the same way but there's no need to collect a paper prescription from us. For more information, please see the information leaflet available online or from reception. If you would like to sign up, which pharmacy would you like to nominate?

Name and location _____

Dispensing appliance contractor (if applicable) _____

CHOICES ABOUT HOW WE SHARE YOUR INFORMATION

There are a lot of decisions to make about how we share your information. Sharing information safely and appropriately helps us and others to care for you. More information on all these decisions is available on request and staff will be happy to help you understand your choices.

Sharing information with family / carers

If you have others (usually family members) involved in your care you can choose to nominate people that we will be able to share information with if you're unavailable. They will also be able to gain information on your behalf. You can change this at any time.

I give consent for the below named to obtain and/or receive information from the practice either for:

☐ Anything regarding appointments, prescriptions, results and sick notes

☐ Anything personal or any medical information requested

Name _____ Date of Birth _____

Relationship _____ Contact number _____

Name _____ Date of Birth _____

Relationship _____ Contact number _____

Name _____ Date of Birth _____

Relationship _____ Contact number _____

Name _____ Date of Birth _____

Relationship _____ Contact number _____

Sharing information with emergency care services across the country

The Summary Care Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have. Your summary care record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will immediate access to important information about your health.

☐ **I do NOT want a summary care record**. You need to complete the 'opt out' form at the back of this pack.

Children under 16 automatically have a summary care record created for them unless their parent or guardian chooses to opt out on their behalf. If you are a parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Sharing information with other health services that care for you

In order for us to provide better care, we are trying to improve communication between different parts of the health and social care services that you may be involved with. We need your permission to be able to share information and also gain information from other care providers.

We would prefer any service that is involved in your care to be able to access your GP record. This allows them to make better decisions about your care, reduce duplication and minimize the chance of mistakes. The services include:

- Hospital and outpatient clinics, including those in the community
- Emergency and urgent care services, e.g. Emergency Department and out-of-hours GP services
- The ambulance service, East Midlands Ambulance Service
- The community care teams, including community nurses and matrons, physiotherapists, occupational therapists, podiatrists and specialist nurses.
- Child health services, such as health visitors, school nurses.
- Social care services.
- Mental health services, such as counsellors, psychiatrists and community psychiatric nurses.
- Other GP surgeries, who you may choose to see outside working hours, eg in the evening or at weekends.

In order for all your other care providers to get a better understanding of your record, we would like to share your whole GP record. This includes all of your past medical history, your past and present medications, any allergies and all your vaccinations etc. If there is anything on your record that you're concerned about being seen or anything you do not want to be shared please bring this form in to discuss with your GP. We are able to mark items in your record 'private' so it will not be shared.

Only the services you give consent to will be able to see your GP record. You record will not be shared to any other party without your consent. Everyone that has access to your records has a duty to keep your record confidential, unless there is a lawful reason to break it.

You may change your mind at any time. Please note that it is not always possible to separate out a shared record at a later date if you change your mind.

I would / would not *(please delete as appropriate)* like my full GP record at Highcroft Surgery to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see it.

I would / would not *(please delete as appropriate)* like the information recorded by other care teams involved in my care to be seen by Highcroft Surgery where I have granted those care teams the right to add it.

Sharing information for research and other purposes

GP Extraction System (Care.Data) uses Patient records to gather information for purposes other than your direct care e.g. Research, in order to help the NHS plan and improve their services. The information does NOT include your name just your postcode and NHS number. There are strict rules and laws that control how your information is used and shared to protect your privacy. If you prefer NOT to allow the transfer of your data please tick these boxes:

☐ I do not wish my clinical data to be extracted electronically from this GP practice.

☐ I wish to prevent my clinical data gathered from any NHS source from leaving the Health and Social Care Information Centre.

Before signing below please carefully check that you have fully completed this form and all information is accurate.

Signed (patient/on behalf) _____ Date _____

If you are signing on behalf of patient, relationship to patient_____

Thank you for taking the time to complete this form. Please make sure you have a copy of our practice booklet for information about the services we provide and you can also find out more on our practice website www.highcroftsurgery.co.uk.

We also recommend you sign up for our online service for appointment booking and ordering of prescriptions. If you would like to sign up you need to register at reception with photo ID.