Living Well Partnership

Registration Form Age 15+

OFFICE USE ONLY:
RECEPTIONIST INITIAL: _____ **TODAY'S DATE:** _____ **PT ID NUMBER:** _____

Please complete **all** parts of the registration form and return to the surgery with **2** forms of ID (preferably one photographic ID such as passport or driving license and a utility bill) and a copy of your repeat prescription from your previous surgery.

Acceptable identification documents:

Name Identification

- Current signed full passport
- Current UK or current EU/EEA driving licence
- Current benefits or state pension notification letter confirming rights to benefits for the current period
- Current HMRC tax notification e.g. PAYE coding, statement of account (excluding P45s and P60s)
- Shotgun or firearms certificate
- Travel documents issued to foreign nationals granted permission to remain in the UK
- Residence permit issued by the Home Office to EU nationals
- EU/EEA member state identity card

Address Identification

- Recent utility bill/statement showing current address
- Local authority tax bill for current year
- Bank or building society statements
- Credit/store card statement
- Mortgage statement
- Local council rent card
- Tenancy agreement
- Solicitors letter confirming recent purchase of your property

Under 16s - Children under the age of 16 whose parent/guardian is registered with the practice or registering at the same time, will need to provide either and original birth certificate or a certified copy or passport

Which surgery are you registering at? (Please circle) Bitterne Park Ladies Walk Weston Lane St Lukes Harefield Botley Midanbury

Personal Details

Title: Mr / Mrs / Miss / Dr / Prof / Other_____	Next of Kin: Relationship: Contact Telephone:
Forenames:	
Surname:	
Previous Surname(s):	Social Worker (if applicable): Contact Telephone:
Gender:	
Date of Birth:	Previous Address: Post Code:
Email Address:	
Home Telephone:	Previous Doctors Address:
Mobile Telephone:	
Address: Post Code:	
NHS Number:	**If you have any special communication needs, please speak to a receptionist so that we can record this in your notes**
Marital Status:	
Town and Country of Birth:	
Occupation:	

Signature of person completing the form:

Main Language:	Do you require an interpreter? Yes No

Ethnicity:

☐ Asian or Asian British - Bangladeshi	☐ Mixed - White/Asian
☐ Asian or Asian British - Indian	☐ Mixed - White/Black African
☐ Asian or Asian British - Pakistani	☐ Mixed - White/Black Caribbean
☐ Asian or Asian British - other background	☐ Mixed - any other mixed background
☐ Black or Black British - Caribbean	☐ White - British
☐ Black or Black British - African	☐ White - Irish
☐ Black or Black British - other background	☐ White - any other white background
☐ Chinese	☐ Any Other _____

If you are from abroad, this section MUST be completed
We MUST see your original passport and accompanying supporting documentation relating to your entitlement to NHS primary care services. Please note that until your status has been determined, you may be liable for charges for NHS treatment.

Your first UK address where registered with a GP:

Date you first came to live in the UK:

If previously resident in UK, Date of Leaving:

How long do you intend to stay in the UK:

When does your visa expire:

Have you been granted permanent residency: Yes No

Patient Declaration—for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.
However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.
Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.
You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.
The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery.
Please tick one of the following boxes:

☐ I understand that I may need to pay for NHS treatment outside of the GP practice

☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

Signed:

Date:

NHS Organ Donation

I wish to register my details on the NHS organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply:

☐ Any of my organs and tissue or,

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation:

Date:

Health Status

Height:	Weight:
Smoking	
☐ Never Smoked	☐ Current Smoker How many/much per day? _____
☐ Ex Smoker - when did you stop? _____	
Smoking is a major contributor to ill health and greatly increases your risk of heart disease and lung disease. Smokers are advised that it is in their best interest to give up and may self refer to Quitters on (023) 8051 5221 or Quit4Life on 0845 602 4663	
Alcohol	
How many units do you drink a week?	
A unit of alcohol is a small wine glass/1shot of spirit/1/2 pint beer or lager. The recommended weekly allowance of alcohol is no more that 14 units for a woman and no more than 21 units for a man. It is better that the weekly allowance is spread evenly over the week rather than all in one night.	
Exercise	
How would you describe your regular exercise level on a weekly basis?	
☐ Inactive ☐ Light	☐ Moderate ☐ Rigorous
Aerobic exercise is brisk walking, jogging, swimming or cycling. A target level of 30 minutes of moderate aerobic activity on at least 5 days a week is recommended. Moderate activity means any activity that makes you feel warm and slightly out of breath.	

Please indicate if you suffer from or have ever suffered from any of the following medical conditions:

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Asthma
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ Raised blood pressure
- ☐ Chronic Kidney Disease
- ☐ Strokes/TIAs
- ☐ COPD
- ☐ Mental Health Problem
- ☐ Heart Disease
- ☐ Other _____

Do you have any family history we should be aware of?
Please state condition, family member and age of onset

Do you have any allergies—please give details

Please list any regular medication, with the dose you are taking. Please attach a copy of your repeat prescription from your previous surgery.

Please list any serious illness or operations you have had with dates if possible.

Women Only

Have you ever had a cervical smear? Yes No

If yes:

When: _____ Result: _____

Where: _____ Next smear due: _____

If you think you are due a smear test, please speak to a receptionist who can book an appointment for you to have a smear test with one of our Practice Nurses

Are you currently pregnant? Yes No

If yes, estimated date of delivery: _____

Carers

If you are a carer or are cared for, we would like to hold this information in your medical record. This will help us provide support as necessary and have a better understanding of your needs. You may be a carer even if you are a family member. By completing this form, you agree that we can retain this information in your medical record.

Please complete the following sections as appropriate:

I **am** a carer
I care for:
Address:
Contact Telephone:
Relationship (if any):
Is the person you care for registered at this practice? Yes / No

I **have** a carer
I am cared for by:
Address:
Contact Telephone:
Relationship (if any):
Is the person who cares for you registered at this practice? Yes / No
Are you registered disabled? Yes / No

Armed Forces

If you are a Armed Forces Veteran, Reservist or part of an Armed Forces family please complete this section. Armed Forces Veterans, Reservists or members of Armed Forces families have certain rights with respect to NHS Services. More information about your rights is available here—https://www.nhs.uk/using-the-nhs/military-healthcare/priority-nhs-treatment-for-veterans/

By completing this section of the form you are agreeing to retain this information in your medical record.

I am an…	
Armed Forces Veteran	☐
Armed Forces Reservist	☐
Member of an Armed Forces Family	☐

If you are returning from the Armed Forces:

Address before you enlisted:

Enlisting Date:

Consent

Text Messaging Appointment Reminder Service. Your mobile number will only be used by the GP Practice in support your healthcare or to provide information about treatment and services offered by the GP Practice. It will not be passed to any other parties. Please see our Privacy Notices for full details on how we use your data.

☐ Opt In ☐ Opt Out

Electronic Record Sharing

I consent to share my data confidentially with other healthcare professionals. Details of who your data may be shared with can be found in our Privacy Notices, available on our website.

☐ Yes ☐ No

Carers

I give consent to the following people to discuss medical matters or collect prescriptions on my behalf:

Name	Discuss Medical Matters	Collect Prescriptions
	☐	☐
	☐	☐

Online Access

I wish to have access to the following online services:

- Booking Appointments
- Repeat Prescriptions
- Medical Record—Medication History, Immunisations and Allergies

☐ Yes ☐ No

Patient Participation Group

We would like to invite you to join our Patient Participation Group. The aim of this group is to advise the practice from a patient perspective and provide insight into the responsiveness and quality of services we provide. The group also encourages other patients to take greater responsibility for their own and their families health.

We hold meetings 4 times a year and we may also send you emails to gather your views.

I agree to register to join the Living Well Partnership Patient Participation Group.

☐ Yes ☐ No

Privacy notices

Privacy notices are a legal requirement and contain information about how Living Well Partnership uses the personal and healthcare data we collect and hold about our patients.

Following changes to General Data Protection Regulations (GDPR), we have updated our privacy notices. These can be viewed on our website or a copy can be provided by reception.

Consent to Share and Leave Messages

My Details	
Full Name:	
Date of Birth:	
Address:	

I give consent for Living Well Partnership to leave messages on my answer phone at the following numbers:				
Contact Number:	Home	Work	Mobile	Other
1 -	☐	☐	☐	☐
2 -	☐	☐	☐	☐
3 -	☐	☐	☐	☐
4 -	☐	☐	☐	☐

I give consent for Living Well Partnership to:

☐ Leave messages about any aspect of my medical treatment

☐ Discuss medical matters

with the following third parties:

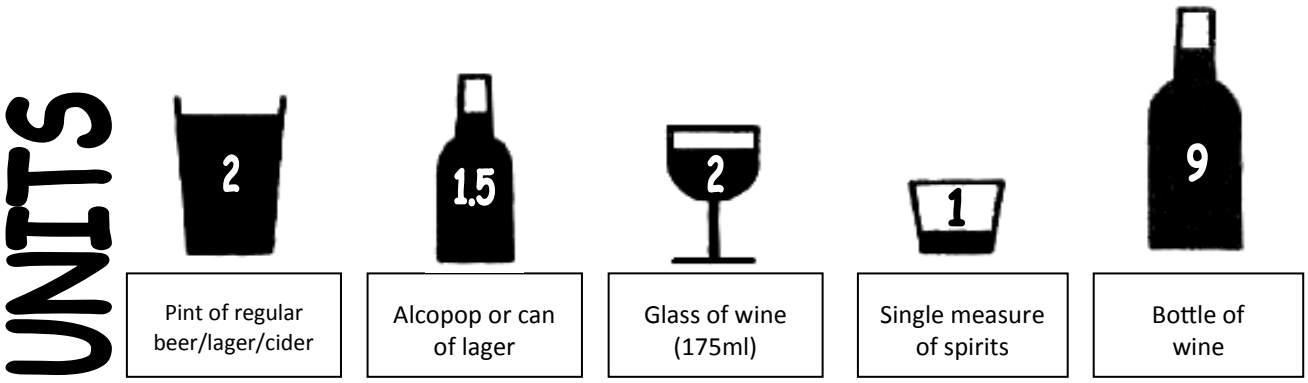
Name:	Relationship	Contact number
1 -		
2 -		
Can these people pick up prescriptions on your behalf? ☐ Yes ☐ No		
Signed:	Printed:	

If you want your consent to cease, please contact a receptionist. An acknowledgement of your cease to consent will be sent you at the address we hold on record for you.

Communication Preferences

Can you confirm how you would like us to contact you and tell us which is your **preferred** way to be contacted.			
Email	☐ Yes	☐ No	I prefer to be contacted this way ☐
Text	☐ Yes	☐ No	I prefer to be contacted this way ☐
Letter	☐ Yes	☐ No	I prefer to be contacted this way ☐
Telephone	☐ Yes	☐ No	I prefer to be contacted this way ☐
Blood results by text: I would like to receive any test results by text: Yes ☐			

Name: Date of Birth:



Fast Alcohol Screening Test (FAST)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
ONLY ANSWER THE FOLLOWING QUESTIONS IF YOUR ANSWER ABOVE IS MONTHLY OR LESS						
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	
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	
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	

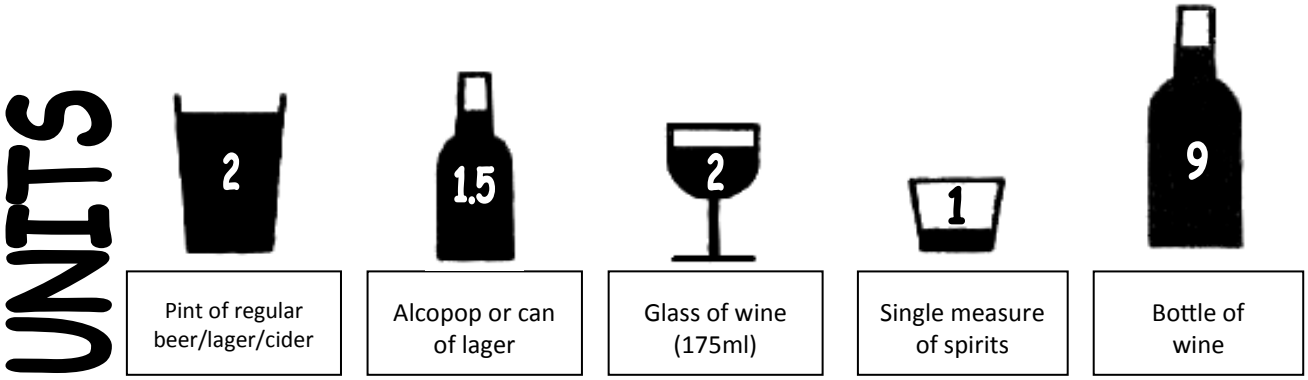
Scoring: A total of 3+ indicates hazardous or harmful drinking

Single Alcohol Screening Questionnaire (SASQ)

Men:	When was the last time you had more than 8 drinks in one day?			
Women:	When was the last time you had more than 6 drinks in one day?			
Select One:	Never	Over 12 months	3-12 months	Within 3 months

Scoring: Within 3 months indicates hazardous or harmful drinking

Name: Date of Birth:



Alcohol Users Disorders Identification Test (AUDIT)

	Scoring System					Your Score
	0	1	2	3	4	
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	7-8	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	

Scoring: 0 – 7 = sensible drinking, 8 – 15 = hazardous drinking, 16 – 19 = harmful drinking and 20+ = possible dependence