Richmond Surgery
Fleet, Hampshire

Registration Questionnaire

for all new patients aged 16 or over

Personal Details

Surname ………………………………….………….… Forename(s) …………………………………………

Previous Surname / Maiden name ……………………………….……………… Mr / Mrs / Ms / Miss

Address ……………………………………………………………………………………………………

………………………………………………………………………… Post Code ……………………..……

NHS No. ……………………………………………………..…. Date of Birth ………..………………..

Country of Birth …………………………...……….…… Town ……………….……….…………..

Ethnic Origin……………………………… Occupation...……………………………………………………..

First Language ☐ English ☐ Other (Please state) ……………………………………………………....

GDPR

The introduction of GDPR in May 2018 means we must ask for your permission to send you appointment reminders, health check reminders or our monthly newsletter. **Therefore, please let us know if we may contact you:**	**Yes**	**No**
By text for appointment and health check reminders, surgery info (e.g. staff training)?		
By email with surgery health check reminders, surgery info (e.g. staff training) and our monthly newsletter?		

Contact Details

The surgery number is 'withheld'. Please make sure your contact numbers will accept such calls.

Email address* ……………………………………………………………………………………..……

Home Tel No ……….…………………………….Mobile Tel No* ……….…………………………………..

***For your security and confidentiality,**
the recommendation is not to provide shared contact details

Sharing Data Consent

I do consent / I do not consent (Please delete as appropriate)

to electronic information that identifies me to be shared outside of my GP practice e.g. with other health organisations such as hospitals/out of hours service/A&E (other than where necessary by law, e.g. if there is a public health emergency). Please ensure you have read the information leaflet and fully understand the implications if you choose to not consent to information sharing.

Signed …………………………………………………… Date ………………………………

Medical Details

Height ……ft …… ins *or* .….m ….. cm **Weight** …… st .….. lbs *or* ………… kg

Blood Pressure: Sys …….. Dia ……… Pul …….. (Please use the machine in the waiting room to record the results)

Drug or other Allergies Have you ever had an allergic reaction? ☐ Yes ☐ No

Please specify: ………………………………………………………………………………………..

Do you Smoke? ☐ Yes and I smoke ……………….. per day

☐ No I stopped smoking ………………………….. (enter date)

☐ No I have never smoked

Alcohol Survey - If you could complete this page as fully as possible we would be very grateful. It will help us to help you take the best care of your health.

Alcohol Consumption

How many units do you drink per week**?** …………………
(1 pint beer = 2 units, small wine or pub measured short = 1 unit)

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ 2-3 times a week
☐ Monthly or less ☐ 4 or more times a week ☐ 2-4 times a month

How many units did you have on a typical day when you were drinking in the past year?

☐ None, I do not drink ☐ 3 or 4 ☐ 5 or 6
☐ 1 or 2 ☐ 7 to 9 ☐ 10 or more

How often did you have six or more units on one occasion in the past year?

☐ Never ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ Daily or almost daily

OR …………….. ☐ I am an ex-heavy drinker of ………… units per week and I stopped on ………../ …./ ……

Alcohol Habits

How often during the past year have you found you were unable to stop drinking once you started?

☐ Never ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ Daily or almost daily

How often during the past year have you failed to do what was normally expected from you because of your drinking?

☐ Never ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ Daily or almost daily

How often during the past year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ Daily or almost daily

How often during the past year have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ 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 ☐ Monthly ☐ Weekly
☐ Less than monthly ☐ Daily or almost daily

Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

☐ No ☐ Yes, but not in the last year
☐ Yes, during the last year

Medical History

If you suffer from any of the following conditions, please tick and if you cannot remember the exact dates of diagnosis, just enter the year.

	✓	Year		✓	Year
Coronary/Ischaemic Heart Disease			Epilepsy		
Heart Attack (with age if known)			Hypothyroidism		
Angina			Cancer		
Stroke (with age if known)			Depression		
Hypertension (*on tablets* for high blood pressure)			Kidney Disease		
Atrial Fibrillation			High Cholesterol		
Diabetes			Mental Illness/ Psychosis		
Asthma					
Other (please give details)					

Family Medical History

If any members of your close family suffer from any of the following conditions, please tick.

	Mother	**Father**	**Brothers**	**Sisters**
Heart Attack (with age if known)				
Angina				
Stroke (with age if known)				
Hypertension (*on tablets* for high blood pressure)				
Diabetes				
Cancer				
Asthma				

Medication

Are you currently taking medication? ☐ Yes * ☐ No
*Please advise where you would like your prescriptions sent to i.e. your 'Nominated Pharmacy' :

____

*If these are prescription only medicines, please bring your last repeat script or the box(es) with labels so that we may continue to issue your medication.

Please advise of any other medication you take that has been initiated or managed by a hospital.

____

____

In certain circumstances, your doctor may wish to see you before prescribing further medication.

Carers

If you are a carer, please complete the following information. We keep a carer's register so that help and advice can be made available to support you.

I am the carer for ____ (Name)

____ (Address)

Your relationship to the person you care for: ____

Is this person registered with the practice? ☐ Yes ☐ No

Please complete a Carer's Registration Form and hand in to reception

Do contact the Hampshire County Council for further information on help offered to registered carers.

Emergency Contact Information

In an emergency there may be a need for us to speak to a family member or your next of kin. If you consent to this, please supply the following information.

Name: …………………………………………………………. Relationship to you: …………………………………

Address: ……………………………………………………………………………………………..……………………………

Next of Kin: Yes / No Can discuss medical record: Yes / No

Urgent contact number: (Home) …………………..…………….. (Work) ………………………………..

(Mobile) ………………………………..

IT IS VERY IMPORTANT THAT YOU KEEP US INFORMED OF ANY CHANGES TO YOUR DETAILS

Patient Declaration

I confirm the information provided on this form is correct and I agree to the Practice terms on information sharing.

Signed ……………………………………………………… Date ………………………………

Office Use Only: Type of ID provided ……………………

Checked by …………………………….. Entered by ………………………………

Patient consents to electronic record sharing read code: Initial SCR Consent 9Nd7

Patient does not consent to electronic sharing read code: Opt out 9Nd1

Application for Access to GP Online Services For Adults & Children aged 13yrs +

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Things to consider:

Forgotten history
There may be something you have forgotten about in your record that you might find upsetting.

Abnormal results or bad news
If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

Choosing to share your information with someone
It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

Coercion
If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

Misunderstood information
Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

Information about someone else
If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information
For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:
Keeping your online health and social care records safe and secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf

- Registration for Online Services is only available to patients aged 13 and above.
- All users must have their own individual email address.
- Family email addresses cannot be accepted.
- Previous users of online services MUST re-register for the new online services.

FOR NEW USERS OF ONLINE SERVICES:
- Please complete the application form and bring this to the surgery with TWO forms of ID:
  - 1: Photo ID e.g. passport or driving licence

  AND
  - 2: Confirmation of your current address e.g. bank statement / utility bill.

Richmond Surgery
Fleet, Hampshire

Application for Access to GP Online Services
For Adults & Children aged 13yrs +

Surname		First Name	
Address			
Postcode		DOB	
Email address*			
Telephone number		Mobile number**	

*I confirm this is my personal email address for my sole use and I accept full responsibility for my online access user ID and password being sent to this email address.

**I confirm my mobile telephone number may be used for surgery purposes/notifications only

I wish to have access to the following online services (please tick):		
	Yes	**No**
Booking appointments		
Requesting repeat prescriptions		
Accessing my summary care record (*medication, allergies and adverse reactions)* *[93440]*		

I wish to access my online medical record. I understand and agree with each of the following statements:
• I have read and understood the information leaflet "Keeping your online health and social care records safe and secure" – available online at: http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf
• I will be responsible for the security of the information that I see or download
• If I choose to share my information with anyone else, this is at my own risk
• I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
• If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

Signed		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			
Date passphrase collected		Add EMIS Read Code: 91B	
Give this completed form to admin to scan document into patient's records			