ADULT Registration Form

Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ **Completed & Signed form below**
- ☐ **Completed & Signed GMS1 Form**
- ☐ **Photo Proof of ID** ***e.g. Passport, Photo Driving License or Photo ID card***
- ☐ **Proof of Address x 2** ***e.g. Bank statement, Utility Bill, Council Tax - Must be in your name & in the last 3-6 months***
- ☐ **Proof of eligibility for NHS treatment e.g VISA / EHIC – E112, E119 or E128**

Your Details:

Name		**NHS No. (If known)**	
Address		**Date of Birth**	
		Home Telephone	
		Work Telephone	
Email		**Mobile Telephone** **Do you consent to text messages?**	☐ **YES** ☐ **NO**

Previous GP	Practice: Address:			
Your Ethnicity	☐ White (UK) ☐ White (Irish) ☐ White (Other)	☐ Black Caribbean ☐ Black African ☐ Black Other	☐ Bangladeshi ☐ Indian ☐ Pakistani	☐ Arabic ☐ Chinese ☐ Other
Your Religion	☐ C of E ☐ Catholic ☐ Other Christian	☐ Buddhist ☐ Hindu ☐ Muslim	☐ Sikh ☐ Jewish ☐ Jehovah's Witness	☐ No religion ☐ Other:
Your Language	What is your main spoken language? Do you need and interpreter: ☐ Yes ☐ No			
Communication	Do you have any specific communication difficulties? ☐ **YES** ☐ **NO** If YES please identify below:			
Do you need to use?	☐ Walking aid ☐ Wheelchair ☐ Other	☐ Hearing aid ☐ Large print ☐ Braille	☐ Lip reading ☐ British sign language (BSL) ☐ Makaton sign language	
Are you currently?	☐ Housebound	☐ Homeless	☐ A Refugee	☐ An Asylum Seeker
Employment	☐ Full-time ☐ Part-time	☐ Student ☐ Unemployed	☐ Carer ☐ House partner	☐ Retired
Have you come from the Armed Forces?	☐ Army	☐ Royal Navy	☐ Royal Airforce	

Carer and Relationship Details:

Who is your next of kin?	Name: Address: Telephone: Relationship:
Are you cared for? **If yes, who by:**	Name: Address: Telephone: Relationship:
Are you a carer? **If yes, who for:**	Name: Address: Telephone: Relationship:
Do you have a lasting power of attorney?	Name: Address: Telephone: Relationship:

CONSENT TO SHARE FORM

1. Your Health information

Do you wish to consent to your GP Practice sharing your health information with somebody other than yourself? ☐ **Yes** ☐ **No**

Please provide details below of those people who you wish to share your information with:

Name:
Address:
Contact telephone details:
Relationship:

Name:
Address:
Contact telephone details:
Relationship:

Name:
Address:
Contact telephone details:
Relationship:

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ **Yes** ***(recommended option)***
☐ **No**

Signature	☐ Signed on behalf of patient
Name	**Date of Birth:**
Date	

Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

For further information, please see: www.nhs.uk/NHSEngland/thenhs/records

Medical Problems:
Have you suffered from any of the following conditions?

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Heart Failure	☐ Kidney Disease	☐ Underactive Thyroid
☐ Epilepsy	☐ High Blood Pressure	☐ Stroke	☐ Cancer- Type:
			☐ Dementia

DO YOU HAVE AN EHCP (Emergency Health Care Plan) in place? ☐ Yes ☐ No

If YES a copy must be provided
If NO – is this something you would like to discuss - ☐ Yes ☐ No

DO YOU HAVE A DNAR (Do Not Attempt Resuscitation) in place? ☐ Yes ☐ No

If YES a copy must be provided
If NO – is this something you would like to discuss - ☐ Yes ☐ No

Family History & any other information:
Please record any significant family history of close relatives with medical problems
(e.g. surgery, heart attacks, stroke, diabetes, high blood pressure, asthma, glaucoma, cancer, liver and kidney disease)

Please confirm which relative e.g mum, dad, brother, sister. Grandparents

Allergies:
Please record any allergies or sensitivities below

Current Medication:
Please check and include as much information about your current medication below
Please give us your previous repeat medication list too if possible

Previous Immunisations:
Please check and include as much information about your previous immunisations below

Are you attending School / College?
Please confirm school / college contact details:

Lifestyle Questions:

Smoking

Do you smoke?	☐ Yes ☐ No ☐ Ex- smoker ☐ Never smoked
How many cigarettes/cigars do you smoke a day?	☐ Less than one ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+
If you smoke a pipe, how many ounces a week?	
Would you like help to quit smoking?	☐ Yes ☐ No For further information, please see: www.nhs.uk/smokefree

Alcohol

How often do you have a drink containing Alcohol?	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 times or more a week
How many units of alcohol do you drink on a typical day 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

How many units in a drink:

Height and Weight

How tall are you?	
How much do you weigh?	
What is your BMI? (if known)	

Exercise

Do you exercise	☐ Yes ☐ No Details:
How often do you exercise?	☐ Sedentary (no exercise) ☐ Gentle (climbs stairs, walking , gardening) ☐ Moderate (running, cycling, swimming regularly) ☐ Vigorous (attends gym regularly)

Women Only

Do you require any contraception?	☐ Yes ☐ No Details:
Are you currently pregnant or think you may be?	☐ Yes ☐ No Details:
Have you been pregnant before? *(if applicable)*	Details:
Date of last cervical smear test? *(if applicable)*	Date: Result:
Date of last mammogram? *(if applicable)*	Date: Result:

Students Only

Students are at risk of certain infections including mumps, meningitis and sexually transmitted infection, as well as mental health issues including stress, anxiety and depression. Please www.nhs.uk/Livewell/Studenthealth

I am less than 24 years old and have had two doses of the MMR vaccination	☐ Yes ☐ No ☐ Unsure
I am less than 25 years old and have had a Meningitis C vaccination	☐ Yes ☐ No ☐ Unsure
If no or unsure, please inform us so a vaccination can be given if need	

Further Details:

Electronic Prescribing

It is safer and quicker for the Practice to send all repeat prescriptions electronically	This means you will NOT need to collect a traditional green paper prescription – your prescription will be sent by computer link to the chemist you have chosen
Please inform us which chemist you would like your prescription sent to: **(This can be changed at any point to suit you)**	☐ Halls – Forest Hall ☐ Lloyds – Forest Hall ☐ Boots – Forest Hall ☐ Morrisons - Killingworth ☐ Asda – Benton ☐ Other (please name)……

Patient Participation Group

We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.

Would you like to be involved in our Patient Participation Group?	☐ Yes ☐ No

Organ Donation

Please state your wishes for organ donation here:	☐ I wish to be a donor ☐ I wish to donate body to medical research ☐ I do not wish to be a donor

Contacting You

We may need to contact you to confirm appointments, test results and any health campaigns. It is your responsibility to keep the Practice updated with any changes to your telephone number, email address & postal address.

Do you give consent for us to contact you by:	**Email**	☐ Yes ☐ No
	Text/SMS	☐ Yes ☐ No

Data Sharing

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations. If you wish to **OPT OUT** please complete the form found with this leaflet.

Signatures

I confirm that the information I have provided is true to the best of my knowledge.

Signature	☐ Signed on behalf of patient
Name	
Date	