NEW PATIENTS REGISTRATION CHECK LIST

Welcome to Primrose Hill surgery, please take your time to fill in your registration form. If you have any questions please ask a reception staff.

Please note we only register on Tuesdays, Wednesdays and Fridays between 3:00 pm and 5:00pm please bring all relevant information/documents.

- Fill the form **completely;** if you have been registered with a doctor before **DO** provide your **NHS number** *(which you can get from previous surgery)* as well as all **immunisations** you had.

- Bring original **proof of Address** from the past 3 months and **Photo ID** such as a passport, driving licence, freedom pass etc.

- Pay attention to the **data sharing** sections at the end of the form and any services you wish to be exempted from.

- Once you have completed your registration form, you will be asked to provide a blood pressure reading which you can do from the BP pod at reception and also a urine sample.

It will take two working days for your registration to be processed after which you can book an appointment.

Please be patient as reception can get very busy and thank you for your understanding.

PATIENT REGISTRATION FORM (ADULT)

WELCOME TO PRIMROSE HILL SURGERY

(REGISTRATION TIMES – TUES, WED, FRI FROM 15:00 – 17:00)

To ensure that we have your correct medical and personal details, please complete this form in its entirety in **CAPITAL LETTERS** or Clear Handwriting. It might delay the completion of your registration, if the sections marked with * are not completed correctly when you hand this form back to our receptionists. Please ask for assistance if needed.

THE INFORMATION YOU GIVE IS CONFIDENTIAL AND IS SUBJECT TO THE DATA PROTECTION ACT

All Marked with *	**REGISTRATION DETAILS**
***TITLE**	Miss / Master / Ms / Mrs / Mr / Other *(Please specify)*
***SURNAME**	
***PREVIOUS SURNAME**	
***FIRST NAME/S**	
***GENDER**	Female / Male /Other *(Please specify)*
***DATE OF BIRTH**	
***PLACE OF BIRTH**	Town: Borough: *(If born in London)*
***COUNTRY OF BIRTH**	County: *(If born in N Ireland)*
***DATE OF ENTRY TO UK**	*dd /mm / yyyy* *(If born outside United Kingdom)*
***HOME ADDRESS IN UK** *(Within our Area)*	
***POST CODE**	
***CONTACT DETAILS**	Mobile No: Home No: E-mail:
***COMMUNICATION CONSENT DECLARATION**	☐ **YES, I CONSENT** to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and for appointment reminders ☐ **NO**, **I DO NOT CONSENT** to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and for appointment reminders
***NHS NO**	
***PREVIOUS HOME ADDRESS**	
***PREVIOUS GP DETAILS**	Name: Address:

***Person to be contacted in case of an emergency**

Name: _____ Contact Number: _____

What is your relationship to this person: _____

***Personal Details**

What is your current occupation/profession?

_____

Do you have children? **YES / NO**

If yes, please give name and date of birth:

_____

_____

Are you registered disabled? **YES / NO**

If yes please give details of your disability

_____

Do you use a mobility aid? **YES / NO**

Stick Frame Wheelchair

Are you Housebound? **YES / NO**

***Carers** *…are people who are looking after a friend, relative, partner or neighbour who cannot manage on their own. The person they are caring for or supporting may be elderly or ill, have a disability, have learning difficulties or a mental health problem, or be a child with special needs*.

Are you a carer for someone? **YES / NO** If yes, are they registered at this practice? **YES / NO**

Name of the person you care for: _____ *Their contact number:* _____

Do you have a carer? **YES / NO** If yes, are they registered at this practice? **YES / NO**

Name of the person who cares for you: _____ *Their contact number:* _____

***Personal Medical History** *(Please list any illnesses, operations, any serious medical problems and the year of onset)*

***Medications** *(All current tablets – when started, dose of medication and how often taken per day)*

***Allergies** *(Have you had a reaction to a medication/food/other? Please give the name/s and the reaction to it)*

*Family History		*Relationship (only mother/father/brother/sister)	*Age when first diagnosed
Heart attack / Bypass Surgery	YES / NO		
High blood pressure	YES / NO		
CVA/Stroke	YES / NO		
Diabetes	YES / NO		
Asthma/COPD	YES / NO		
Cancer *(If 'yes' please give details about the type of cancer e.g. bowel, breast or ovary)*	YES / NO		
Other *(If 'Yes' please give details e.g. muscular dystrophy, haemophilia, sickle cell, polycystic kidneys, and any other illnesses)*	YES / NO		

***Adult Immunisations** *(Please tick if you have had and give date)*

Tetanus ☐ Rubella ☐ Polio ☐ Pneumococcal ☐ Influenza ☐

***Exercise** *(Please tick below how many sessions do you do each week)*

0 ☐ **1** ☐ **2** ☐ **3** ☐ **3+** ☐

1 session = 20 minutes of aerobic activity sufficient to raise your pulse and make you breathless

*__Smoking__

Do you smoke? **YES / NO** *(Please circle)*

If 'No' have you ever smoked **YES / NO** *(Please circle)*

If 'Yes' how many per day: Cigarettes _____ / Cigars _____/ Pipe _____

If you are an ex-smoker, what year did you give up? _____

NOTE: If you are a smoker we strongly advise you to stop. Please ask reception if you would like a booklet to help you to stop smoking

*__Alcohol Use__ **How many units of alcohol do you consume each week?** **TOTAL** _____

(Please circle your answers in Qs 1,2 & 3 below; total the 3 scores; enter total in box below)

Q1. How often do you have a drink containing alcohol?

Never = 0	Monthly = 1	Once a week = 2	2-3 times a week = 3	4 or more times a week = 4

Q2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?

1-2 drinks = 0	3-4 drinks = 1	5-6drinks = 2	7-8 drinks = 3	10 or more drinks = 4

Q3. How often do you have 6 or more standard drinks* on one occasion?

Never = 0	l ess than monthly = 1	Monthly = 2	Weekly = 3	Daily or almost daily = 4

NOTE – A standard drink of alcohol (around 10mls or 8g) is contained in:

- A small glass of standard strength wine -12% (125ml)
- A single pub measure of spirits (25ml) or half a pint of normal strength beer or lager

TOTAL SCORE for Q1, Q2 & Q3 _____

Women with a total score higher than 4 ***Men with a total score higher than 5*** ***Please ask for a Sensible Drinking Pack***	**OR**	***If you are concerned about your level of alcohol consumption, e.g. if this is >21 units in a man or >14 units in a women, please make an appointment to see a doctor or nurse.*** ***If you require alcohol rehabilitation please tick this box*** ☐ ***and detach the self referral details overleaf.***

__Patient Profile__ *(Please indicate which box seems most suitable to you)*

Ethnicity	Please tick	Language/s spoken	CODE
British or mixed British			9i0
Irish			9i1
Other white background			9i2
White and black Caribbean			9i3
White and black African			9i4
White and Asian			9i5
Other mixed			9i6
Indian / British Indian			9i7
Pakistani / British Pakistani			9i8
Bangladeshi / British Bangladeshi			9i9
Other Asian			9iA
Caribbean			9iB
African			9iC
Other black			9Id
Chinese			9ie
Other			9iF
Not stated			9iG

NOTE: If English is not your first language, do you require an interpreter? **YES / NO**

*Women only	DATE	PLACE	RESULT	COMMENTS
Last smear?				
Last mammogram?				

Have you ever had an abnormal smear? **YES / NO** *(Please circle)*
If 'Yes' please give details (date, place, treatment) _____

Have you had a hysterectomy? **YES / NO** *(Please circle)*
If 'Yes' please give details (date, place, treatment) _____

What contraception are you using at present? _____

Have you ever had a blood test to check if you are immune to Rubella (German measles)? **YES / NO** *(Please circle)*
If 'Yes' please give details (date, result) _____

ONE STOP NEW PATIENT CHECKS – OVER 16'S ONLY

To complete your registration we need to know your height, weight, waist measurement and blood pressure and check your urine. We appreciate that you may be busy so we've tried to make it easy for you to supply this information yourself. Please complete the following steps and hand in your form and urine sample to reception. Please ask if you need assistance or advice.

HEIGHT…….. CM OR ……..FT …….INCHES
If you are unsure of your height please use the measuring slide. Position yourself under the measuring slide with your back and head straight. Push the measuring slide onto the top of your head and read off the height at Mark 1

WEIGHT……KG OR ……..STONE …… LBS
Please use scales provided if required. Press green start key. Wait for the display to show 00.00 before you step on the scales. Read the weight off the digital display.

WAIST MEASUREMENT…… CM Use the tape measure and measure around your waist and record this in cm.

BLOOD PRESSURE **Systolic**……..mmHg **Diastolic**…….mmHg

URINE
Please ask for a urine bottle from reception. **Label it with your name, DOB and Date and write NEW PATIENT CHECK on the bottle.** Hand it to reception staff who will test it for sugar and protein at the end of surgery; they will ring you if there is a problem

ROUTINE HIV SCREENING TEST FOR ALL NEW PATIENTS OVER 16Y/O:
We are offering a routine HIV blood test to all our new patients over the age of 16y/o.

The blood test can be performed at the Royal Free Hospital or UCLH and results will come back to the surgery within approximately one week. Please note that the blood test result reflects your HIV status 1 month ago. If you think you have been at risk of HIV in the last month then please book an appointment to see a GP.

If your HIV blood test result is "negative" this means you do not have HIV. We will **not** contact you with this result.

In the unlikely event that your result is "positive" we will be contacting you to discuss the result over the phone or via mail.

Would you like to have an HIV blood test? (please circle) YES NO

How would you like to hear about the result? (please circle) Phone Letter

INITIAL APPOINTMENTS
If you suffer from any chronic condition requiring regular medication please book an appointment with the doctor. Please contact reception for advice if you wish to book an appointment with the doctor or nurse.

Thank you for taking the time to complete your registration – we look forward to offering the services of our health care team to you and your family.

NAME PRINTED IN CAPITAL LETTERS ***SIGNATURE OF PATIENT/ON BEHALF OF PATIENT*** ***DATE***

_____ _____ _____

FOR ADMINISTRATION USE ONLY

EU / UK Passport Holder / Birth Certificate ***ELR/ILR (Exceptional / Indefinite leave to remain)***

Working/Family visa (Length of visa_____) ***Student Visa (Length of visa _____)***

EMIS No: ***Date:***

Receptionists please check that form is fully completed	(please tick box when completed)
Data on EMIS	[ ] (Tick)
Practice leaflet given	[ ]
Receptionist's initials…….. Date……	

Doctor please check the form and assess if follow up appointment is needed

Urine glucose ……. Urine protein…….. ……..

Signed (initial)	Normal no action
	Abnormal send letter
	Abnormal call patient

Once the form has been assessed and the appropriate follow up has been arranged place the form in the scanning in tray. After scanning the form is handed to Jean to merge with the incoming notes.

PATIENT REGISTRATION PROTOCOL

Our Practice welcomes new patients to register at our practice on a daily basis. During the Practice's opening hours you can collect individual adult and/or child registration forms. Together with the completed registration form, you should present **two forms of identification** which proves residency and authenticates your identity. Overseas visitors may be asked for additional information to prove NHS entitlement.

If you have been registered with the NHS before joining our practice, you will also need to provide us with:

- ✓ **Your NHS number**
- ✓ **The full name and address of your previous GP Surgery**
- ✓ **Your previous address**

If you have never been registered with the NHS before, you will need to provide us with

- ✓ **The exact date, month and year of your entry to the UK**

All these should be returned and handed to one of the reception team members to check from 14:00. Any incorrect information may result in the rejection of your registration from Patient Data Department. Please note you cannot book an appointment until your reg istration details are on our system, this is normally done within 48 hours.

✓ *PROOF OF ENTITLEMENT TO NHS (NATIONAL HEALTH SERVICE) TREATMENT*

In order to establish patient's entitlement to NHS, it is necessary to either check nationality through ***ORIGINAL PASSPORT, BIRTH CERTIFICATE, OR FULL DRIVING LICENCE (LEARNERS DRIVING LICENCE WILL NOT BE ACCEPTED)***

✓ *PROOF OF RESIDENCE*

You must provide ***ONE ORIGINAL*** of the proof documents listed below:

1. Electoral Registration
2. Current Council Tax
3. A recent utility bill: electricity, gas, water (last quarter)
4. Formal tenancy agreement or a housing association rent document
5. A recent telephone bill
6. A purchase or ownership document or a letter on original headed paper from your solicitor confirming that you are the legal owner and occupier of the property
7. A recent Employer Pay Slips or Personal Bank Statement. (Company account statements will not be accepted)
8. Affidavit - A Statutory Declaration declared before a commissioner for oaths or practicing solicitor
9. Vehicle registration document (V5C) in your name and showing your address

Recording Consent of New Patients for National and Local Data Sharing Initiatives

Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care.	I want to: Opt out of CIDR. ☐
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your • medication (last 12m) • bad reactions to medicines • allergies when you're admitted to hospital, when treating you in an emergency, or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐
Care.data National Initiative	Care.data aims to make increased use of information from medical records with the intention of improving healthcare via research.	I want my medical record to be part of Care.data. ☐ There are **2 levels of opt out**, you can opt out of both: I do not want my personal and confidential data to leave the Health and Social Care Information Centre ☐ I do not want my personal confidential data to leave the GP Practice ☐