Form:
ADULT

Saltscar Surgery • 22 Kirkleatham St. • Redcar • TS10 1UA
Tel: (01642) 471388 • **Fax:** (01642) 488701
Web: www.saltscarsurgery.nhs.uk

ADULT Registration Questionnaire

Failure to complete in full may result in non-registration.

Today's Date: _____ Date of birth_____ *(dd/mm/yyyy)*

Forenames: _____ Surname: _____

Address: _____

_____ Postcode: _____

Telephone: *(must complete)*_____ Mobile: _____

Do you consent to receive:

SMS/Text reminders of appointments? *Please tick one:* YES ☐ NO ☐

Email messages: *Please tick one:* YES ☐ NO ☐

Automated voice messages *Please tick one:* YES ☐ NO ☐

Next Of Kin Details:

Full Name: _____

Relationship : _____(i.e mother/father/spouse)

Address: _____

Telephone: _____ Mobile: _____

Do you have a Carer? *please tick one* YES ☐ NO ☐ (If so please give details)

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Are you the carer for somebody else? YES ☐ NO ☐ *(If YES please give details)*

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Communication:

Do you have any special communication needs due to a disability or sensory loss? For example do you need information in Braille or use British Sign Language to communicate. *Please tell us below:*

_____

_____

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IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORDS

Please read and choose one of the three options. Ask for help from staff if you are not sure.

Do you give permission for the surgery to share your information with other Healthcare Providers when you visit them to be seen or if you are admitted to A&E in an emergency?

For more information please read the attached leaflet *Your Electronic Health Record*

Please choose and sign just ONE option below:

NOTE: If you choose not to specify a preference, the records will *be shared on the grounds of good medical practice.*

Option 1

After reading the above leaflet I am happy for my full patient record to be viewed by health and care organisations involved in my care **without an extra verification step**.

Signature: _____ Date: _____

Option 2

After reading the above leaflet I DO NOT want my patient data to be viewed by **other** health and care organisations involved in my care.

Signature: _____ Date: _____

Option 3

I would like to provide an extra security code, or online approval to health and care organisations involved in my care in order to view my record.

For this step to work, you must keep your mobile number and email address up to date or have access to your GP online account.

Signature: _____ Date: _____

Shared Information options counter-signed by staff:

Signature: _____ Date: _____

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Ethnic Origin: Please Tick One:

White British	
White Irish	
Other White Background	
Black Or Black British Caribbean	
Black Or Black British African	
Other Black Background	
Asian or Asian British Indian	
Asian or Asian British Pakistani	
Asian or Asian Bangladeshi	
Asian or Asian Chinese	
Other Asian Background	
Mixed White and Black Caribbean	
Mixed White and Black African	
Mixed White and Asian	
Other Mixed Background	
Other Ethnic Background	

Main Language Spoken: _____ 2nd Language: _____

Basic Health: Height: _____ Weight: _____

Do you suffer from any medical condition?
E.g. Heart disease, high/low blood pressure, Diabetes, Asthma, Arthritis etc.

_____

_____

_____

_____

Have you had any operations or investigations? If so please give approximate dates and details.

Approx. date *Investigation or operation*

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently under the care of the hospital? If so please give details:

_____

_____

PLEASE REMEMBER TO CONTACT THE HOSPITAL TO INFORM THEM OF YOUR NEW GP.

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Current medications

Please list the names and dosage of your current medication (if any)

Name of medication	*Dosage*	*Name of medication*	*Dosage*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Important Notice: If you are taking any of these medications:

Codeine, Diazepam, Gabapentin, Pregabalin,
Temazepam, Tramadol, Zolpidem, Zopiclone

(or drugs similar to these) by agreeing to be registered at this surgery, you are agreeing to enter any reduction programme the doctor deems necessary.

Do you have any allergies, if so please give details:

_____

_____

Has your mother, father, brother or sister suffered from any of the following?
Please circle yes or no.

Heart disease below the age of 60	YES / NO	Stroke	YES / NO
High blood pressure	YES / NO	Asthma	YES / NO
Diabetes	YES / NO	Glaucoma	YES / NO

What is your present occupation? _____

(If retired, please state your former occupation)

Have you any other medical or social concerns of which you might wish us to be aware of?

Do you have any reasonable Adjustments due to health conditions we need to consider?

_____

_____

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What is your current smoking status?

I have never smoked ☐ I'm an ex-smoker and quit about _____ ago

I'm a smoker ☐ I smoke about _____ a day

Alcohol audit:

IN THE LAST YEAR - *please* (*circle*) *the appropriate answer boxes*:

1. *Men:* How often do you have EIGHT or more UNITS on one occasion?
   Women: How often do you have SIX or more UNITS on one occasion?

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 health worker been concerned about your drinking or suggested you cut down?

No	Yes, on one occasion	Yes, more than once

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If you would like online access to the surgery – DOWNLOAD the NHS App. (only available for patients aged 13 & over Scan the QR code below

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Summary Care Record

The new NHS Summary Care Record is being introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record will contain basic information about any **allergies you may have, unexpected reactions to medications and any prescriptions you have recently received**. The intention is to help clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

If you choose not have to have a Summary Care Record, (although you are strongly recommended to do so), at any time in the future you may change your mind. All you need do is write to the Surgery informing them of your decision to "Opt-In".

Please tick ONE box: I would like to have a Summary Care Record YES ☐ NO ☐

More information can be found at
https://www.nhs.uk/using-the-nhs/about-the-nhs/your-health-records/

Thank you for taking the time to complete our new patient questionnaire.

We may invite you to take a new patient health check.

For office use only – *Admin clerk to confirm each entry is checked and coded*

☐ SMS	☐ Record sharing	☐ NoK
☐ M-jog	☐ Med Hist & Ethnicity	☐ Recoded
☐ SI / SMS Consent	☐ SCR	☐ Tasked to clinician
☐ Online access verified	☐ Login issued	

Input by: _____ Date: _____