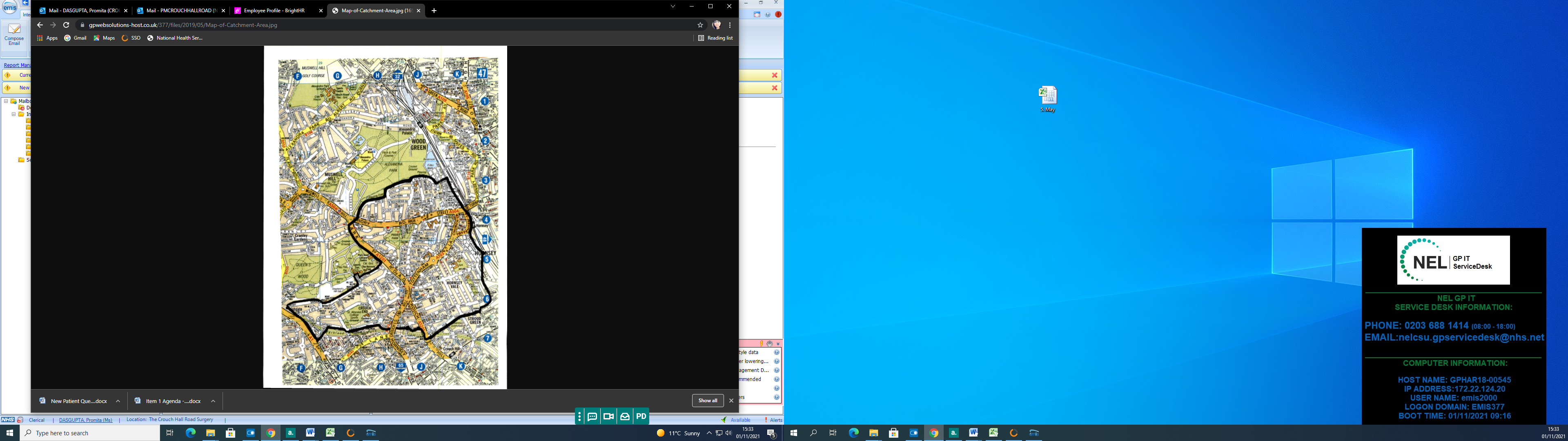
|  |
| --- |
| <http://www.gpwebsolutions-host.co.uk/377/files/2012/02/pic.png>**The Crouch Hall Road Surgery** |
| **48 Crouch Hall Road** |
| **London N8 8HJ** |
| **Tel: 020 8340 5952** |
| **Fax: 020 8340 3384** |
| **Email: crouchhallroadsurgery@nhs.net** |
| **Web: www.crouchhallroadsurgery.nhs.uk** |
|  |

**REGISTRATION TIME: WEDNESDAY & THURSDAY 2:00pm- 6:00pm**

Dear Patient,

Thank you for applying to register with Crouch Hall Road Surgery as a new or returning patient. Please see you are in within our catchment area. If you are outside of our catchment area please arrange to speak to the practice Manager regarding your registration.



In order for your application to be processed accordingly, you must provide the following:

1. **Completed** NHS GMS1 registration form ***Attached***
2. **Completed** New Patient Health Questionnaire ***Attached***
3. **Proof of Photographic I.D**: your Passport or Driving Licence
4. **Proof of Address**:

* Your Utility Bill
* Council Tax Bill
* Tenancy Agreement
* Bank Statement

1. **Children (up to the age of 16), can only be registered** if their parent/ guardian is registering or registered here.
2. **All children** registering must supply their **Red Book** showing the child’s name and NHS number. **(Failure to supply immunisation history may delay your registration).**

* Please bring all your current medication or your repeat prescription sheet with you for your first appointment.

If you are aged 40 and 70 you will be required to book an appointment for a health check with one of our nurses.

We ask all patients for etiquette within the practice, which means patients must:

* Cancel appointment if you cannot attend
* Call to let us know if you are running late- any longer than 10 minutes late you will not be seen.
* Notify us immediately when there are changes in details such as names, address, and contact details.
* Adhere to practice Zero Tolerance Policy
* Adhere to practice complaints and compliments policy.

## NEW PATIENT APPLICATION TO JOIN THE PRACTICE LIST

Welcome to Crouch Hall Road Surgery. Please complete this application form so we can trace your medical notes and meet your health needs efficiently. You will need to bring proof of identification (eg passport, photo driving licence) and proof of residency (eg a utility bill dated in the last 3 months) with this form for us to see. When you have registered we will arrange an appointment with a Practice Nurse for your New Patient Health Check.

Please note that **all staff working for the NHS has a legal duty to keep information about you confidential**.

**PATIENT DETAILS:**

Title: Mr  Mrs  Ms  Miss  Other …………………… Gender: Male  Female  Transgender  Gender Fluid

Full Name: ………………………………………………….. Marital Status: …………….…Maiden Name: …………...…………….

Date of Birth: ………………………………… Place of birth:…………………………First Language:……………………………….

Home Phone Number: ………………………………. Mobile Number: ………………………..……… (We will use this to send

appointment reminders) Email Address:………………………………….......................................

Next of Kin’s Name ………………………………..………….… Next of Kin’s telephone number:…………..………………………

Next of Kin’s relationship to you: …………..……………………………………………………………………………………………..

Current Address ….……………….……………………………..…………………………………………………………………………

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

Please list other residents of your home who are registered with us (Name and DOB):

……………………………………………………………………….………........................................................................................

……………………………………………………………………….………........................................................................................

Would you like to register for online access? Yes / NoPlease ask at reception for log on details once registered.

(Please complete Box 15)

Ethnicity: (please tick)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White** |  | British |  | Irish |  | Any other white background |  |  |
| **Black or Black British** |  | Caribbean |  | African |  | Any other black background |  |  |
| **Mixed** |  | White & Black Caribbean |  | White & Black African |  | White & Asian |  | Any other mixed background |
| **Asian or Asian British** |  | Indian |  | Pakistani |  | Bangladeshi |  | Any other Asian background |
| **Other Ethnic Groups** |  | Chinese |  | Any other ethnic group |  |  |  |  |

**Ethnic Category Refused**

Do you need an interpreter? (Please tick)

|  |  |  |  |
| --- | --- | --- | --- |
| Arabic | Hindi | Urdu | Bengali/ Sylheti |
| Polish | Farsi | French | Portuguese |
| Guajarati | Punjabi | Other Language (Please state)............................... | |
| Are you currently? | Homeless  Refugee | Asylum Seeker | |
| Are you an ‘Assistance Dog’ user? | Yes | No | |
| Are you housebound? | Yes (please answer the question below) | No | |
| If yes please state the following:  Carer’s name:………………………..……………………………. Carer’s telephone number:…………………………….…….…....  Carer’s relationship to you:………………………………………… Carer’s address: ……………………….…….…....................... | | | |



Looking after a family member

Are you looking after someone?

|  |  |
| --- | --- |
| Yes | No |

Let us know if you are looking after someone who is ill, frail, disabled or has mental health and or/ emotional support needs, or substance misuse problems.

Is someone looking after you?

|  |  |
| --- | --- |
| Yes | No |

Let us know if a family member, friend, or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.

Carer’s name:………………………..…………………..……. Carer’s telephone number:……………….……………….…….…....

Carer’s relationship to you:…………………………...…... Carer’s address: ……………………….…….…...................................



**If returning from the armed forces please state which below:**

Army

Royal Navy

Royal Air Force



**Women Only**

What is the date of your last smear test? Date:…………… Result:………………Was this at your GP Surgery?  Yes  No

Date of last mammogram (if applicable:)………..……... Which Hospital/ Centre?…………………………………………...……...

Do you wish to see a female doctor in this practice for contraceptive services (including the pill, coil, implant)  Yes  No



Your Medical Background

Please state any allergies and sensitives you have to medicines, food and dressings (i.e. penicillin, aspirin, plasters, nuts, bee stings etc.):

……………………………….….……………….…….…....……………….………………………………………………….…….…....

Please state any mental disabilities you have:

……………………………….….……………….…….…....……………….………………………………………………….…….…....

What chronic medical conditions do you have? Please select all that apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes | Type 2 Diabetes | Hypertension | Epilepsy | Heart Disease | Mental Health |
| COPD /Emphysema | Asthma | Cancer (please state)  …………………………………….…… | | Other (Please state)  …………………………………….……... | |

Current Medication

Please list any tablets, medicines or other treatments you are currently taking/ undertaking: …………………………………….

…………………………………….……………………………………….………………………………………………….....…………...

…………………………………….……………………………………….………………………………………………….....…………...

Are you able to take your own medicines?  Yes  No

**If no** please give details e.g. swallowing or opening containers: ……………………………………….…………………………….

We provide electronic presciring (EPS), which means your prescriptions are send via computer to your choice of pharmacy, ready for your collection.

Would you like to select your pharmacy to collect your prescriptions from?

Yes  No

**If yes** what is the name and address of this pharmacy? …………………………………….………………………………………

…………………………………….……………………………………….………………………………………………….....…………...



Lifestyle

Are you currently a smoker? Yes  No

Have you ever been a smoker?  Yes  No

If you smoke, how many cigarettes/ cigars/ tobacco do you smoke in a week?

|  |  |  |
| --- | --- | --- |
| Cigarettes: | Cigars: | Tobacco (grams): |

If you are a smoker and want to **STOP** please tick here:

Have you taken any recreational drugs in the past/ currently taking any? i.e. weed, cocaine, MDMA  Yes  No

How much alcohol do you drink in a week? (units) …………………………………….………………………………………

(1 unit = 1 small glass of wine/ single measure of sprits/ ½ pint of beer)

(Please complete the Audit C test towards to back)



Diet and Exercise

What type of diet do you have? Healthy  Unhealthy  Vegetarian  Vegan  other (please state)……………………

How much exercise do you do?  Sedentary (No exercise)  Gentle (climbs stairs, walking, gardening)

Moderate (cycling, swimming regularly)  Vigorous (hiking, skiing, gym regularly)



Family History

Are there any serious diseases such as e.g. Diabetes, Asthma, Thyroid disorder, Stroke, COPD, Heart attack, Cancer, high blood pressure that affect your parents, brothers, sisters or children?

|  |  |  |
| --- | --- | --- |
| **Family Member** | **Health Problem** | **Year of Death**  (if appropriate) |
| Father |  |  |
| Mother |  |  |



Sharing your medical record

Medical record sharing allows your complete GP medical record to be made available to authorise healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.

If you **do not want** to share your GP record tick here:

Summary Care record contains details of your key health information- medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permissions before anybody looks at your summary care record.

If you **do not want** to have a summary care record tick here:



Patient Participation Group (PPG)

The practice is committed to improving the services we provide to our patients.

* To do this, it is vital that we hear from people about their experiences, view, and ideas for making services better.
* By expressing your interested, you will be helping us plan ways of involving patients that suit you.
* It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the practice.

|  |  |
| --- | --- |
| Yes I am interested in becoming involved in the PPG | No I am not interested in becoming involved in the PPG |



Other information

Have you nominated someone to speak on your behalf e.g. a person who has power of Attorney?

Yes  No

If yes, please state their:

Name: …………………………………….…………………………………………………………………………….……………………

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

Phone Number: …………………………………….……………………………………………………….………………………………



Online Access

Would you like to access booking/ cancelling appointment, ordering repeat prescriptions and your summary care record online?  Yes  No

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download |  |
| 1. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement. |  |
| 1. If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential. |  |

**FAST ALCOHOL SCREENING TEST [FAST]**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| **Only answer the following questions if the answer above is Less than monthly (1) or Monthly (2). Stop here if the answer is Never (0), Weekly (3) or Daily (4).** | | | | | | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | monthly | weekly | 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 | Less than monthly | monthly | weekly | Daily or almost daily |  |
| 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 |  |

**Scoring:**

* A score of 0 on the first question indicates FAST negative, you do not need to answer any more questions.
* A total of 1 – 2 on the first question then continue with the next three questions.
* A total of 3 – 4 on the first question, this is a positive screen, go straight onto the

AUDIT questions overleaf

* An overall total score of 3 or above is FAST positive. Go onto ask AUDIT overleaf.

**SCORE**



**Bottle of wine**

**[12.5%]**

**250ml glass of wine (12%)**

**440ml can of “super strength” lager**

**440ml can of “regular” lager or cider**

**Alcopop or a 275ml bottle of regular lager**

**A pint of “strong”/  
”premium” beer, lager or cider**

**A pint of regular beer, lager or cider**

**Remaining AUDIT C questions**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly  or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | 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 |  |

**Scoring:**

0 – 7 Lower risk

8 – 15 Increasing risk

16 – 19 Higher risk

20+ Possible dependence

**SCORE**