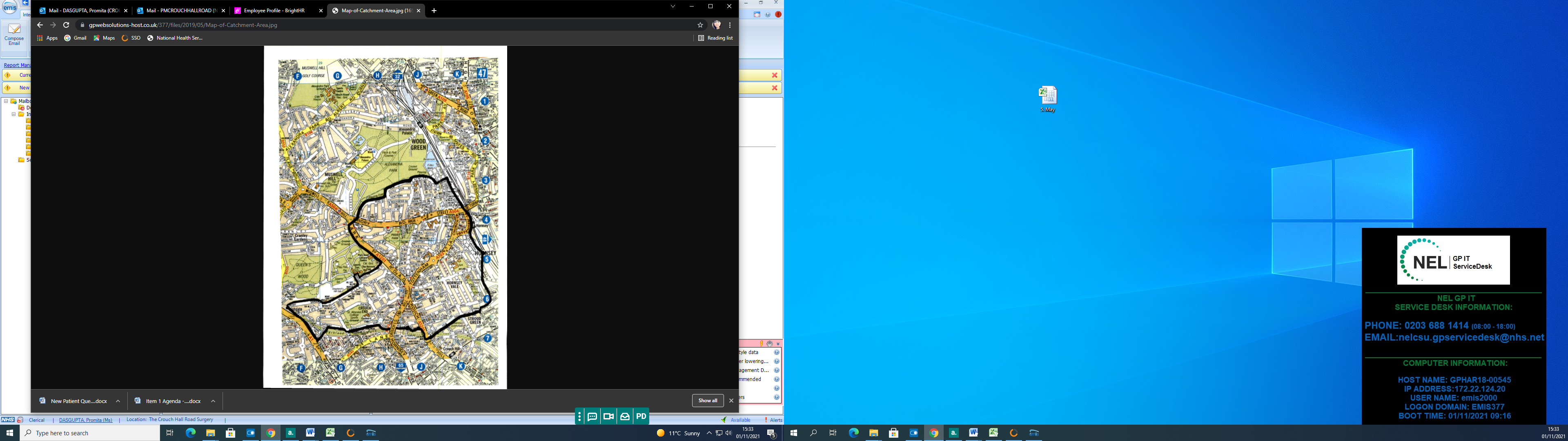
|  |
| --- |
| <http://www.gpwebsolutions-host.co.uk/377/files/2012/02/pic.png>**The Crouch Hall Road Surgery** |
| **48 Crouch Hall Road** |
| **London N8 8HJ** |
| **Tel: 020 8340 5952** |
| **Fax: 020 8340 3384** |
| **Email: crouchhallroadsurgery@nhs.net** |
| **Web: www.crouchhallroadsurgery.nhs.uk**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

**Children’s Registration Form (under 16 years old)**

**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, can you provide the following:

1. **Completed** NHS GMS1 registration form ***Attached***
2. **Completed** New Patient Health Questionnaire ***Attached***
3. **Proof of Photographic I.D**: Passport
4. **Children (up to the age of 16), can only be registered** if their parent/ guardian is registering or registered here.
5. **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.

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**

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: ……………………….…….…...................................



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? …………………………………….………………………………………

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



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:

**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**