# SUTHERGREY HOUSE MEDICAL CENTRE

## 37a St John's Road, Watford, WD17 1LS

**THIS IS A NEW PATIENT REGISTRATION FORM FOR ADULTS**

- **THIS FORM IS NOT FOR TEMPORARY REGISTRATION**
- **THIS FORM IS NOT FOR CHILDREN 0-16 YEARS OLD**
- **NEW PATIENTS SHOULD BOOK AN APPOINTMENT AS SOON AS POSSIBLE FOR A HEALTH CHECK WITH A MEMBER OF THE HEALTHCARE TEAM TO ENSURE THAT ANY REQUIRED TESTS ARE UP TO DATE AND THAT WE HAVE AN ACCURATE NOTE OF ANY REPEAT MEDICATION YOU MAY BE TAKING**

**WRITE ONLY IN CAPITALS**

1. **BRING PROOF OF IDENTITY AND A PHOTOCOPY**
2. **BRING PROOF OF ADDRESS**
3. **COMPLETE A GMS1 FORM**
4. **COMPLETE THIS FORM AND RETURN ALL PAGES**

**HELPFUL PATIENT INFORMATION LEAFLETS, FORMS & OPT OUT DETAILS CAN BE FOUND AT: www.suthergrey.com**

| ***For Surgery Use Only*** | | |
|---|---|---|
| Date Completed | | |
| Confirmation of address seen? | | |
| First Appointment With | | |
| If resident at a Care Home record Residential Institute (Registration Details/Other) | | |
| Audit C Info | Completed YES/NO | Input YES/NO |
| Smoking Info | Completed YES/NO | Input YES/NO |
| Ethnicity Info | Completed YES/NO | Input YES/NO |
| Alcohol Info | Completed YES/NO | Input YES/NO |
| Asthma/Diabetes | Inform relevant nurse | Completed YES/NO |
| Forms Ready For Scanning | | |
| SCR | SCRIM 9Ndl SCRNO 9Ndo | |

# SUTHERGREY HOUSE MEDICAL CENTRE

## 37a St John's Road, Watford, WD17 1LS

### All Patients To Complete ALL Of The Following Sections + GMS1 Form

**Temporary patients only need to complete a GMS3 form**

## CONFIDENTIAL MEDICAL REGISTRATION FORM

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

**Title**: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

☐ Male ☐ Female

Mobile number:

Email address:

## Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital?
If so please enter details below:

| | | | |
|---|---|---|---|
| **High Blood Pressure** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** | **Diabetes** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** |
| **Heart Disease** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** | **Angina** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** |
| **Epilepsy** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** | **Stroke** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** |
| **Asthma** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** | **Cancer** (Please add approximate date of diagnosis if known) | **YES☐ NO☐** |

| | | | |
|---|---|---|---|
| **If Asthmatic**, have they used their inhaler in past 12 months? | **YES** ☐ **NO** ☐ | | |

## Immunisations ……

**Please bring in a copy of any previous vaccinations**

| Immunsation | Year | Immunisation | Year |
|---|---|---|---|
| Tetanus | | 1st MMR (Measles , Mumps or Rubella) | |
| Typhoid | | 2nd MMR | |
| Hepatitis A | | Yellow Fever | |
| Polio | | Hepatitis B | |

If in doubt, it is recommended you arrange an appointment with the Nurse to have another immunisation as it is quite safe to do so.

## Allergies ……

Please list any allergies you have to any drugs/medication:

| Name of medication | What was the problem or upset? |
|---|---|
| | |
| | |

## List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

| Name of medication | Dosage |
|---|---|
| | |
| | |
| | |

## Lifestyle ……

Please enter your height & weight:

| Height: | Weight: |
|---|---|
| | |

## Lifestyle smoking ……

Do you smoke: ☐ Yes ☐No

Would you like help to quit smoking? ☐ Yes ☐No

If yes, do you smoke: ☐ Cigarette ☐Cigars ☐Pipe

Are you an ex-smoker? ☐ Yes ☐No When did you give up?

How many cigarettes/ cigars do you smoke daily?

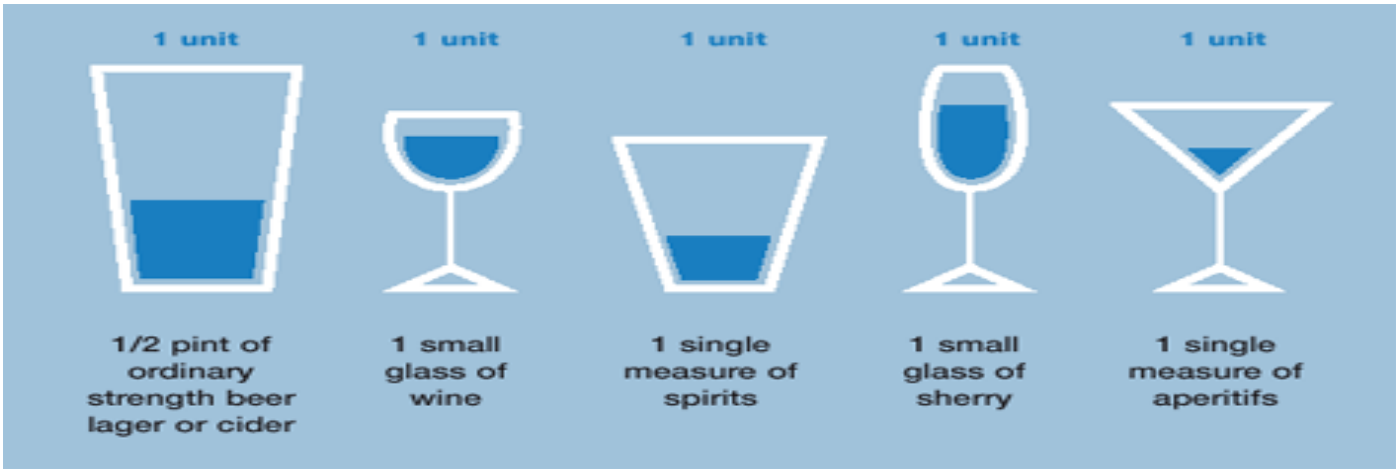
If you smoke a pipe how many ounces a week ?

**Lifestyle alcohol ……**

**Please complete if 16 years or over;**

**Do you drink alchol:** ☐ **No** *go to page 6 Ethnicity* ☐**Yes** *If yes answer the following questions*;

**This is one unit of alcohol…**




## AUDIT – C

| 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 - 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 | |

**Scoring:**

A total of 5 or more indicates possible increasing or higher risk drinking.

An overall total score of 5 or above is **AUDIT-C** positive. **If your score is 5 or more please complete the next section for a complete AUDIT-C score**

**SCORE**

**Remaining AUDIT-C questions (if you scored 5 or more)**

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| 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 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 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 | |
| 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 | |
| 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 | |
| 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 | |

Total score, equals AUDIT C Score plus Score of remaining questions above;

Your total Audit Score = _____ (section 1+ section 2)

| | |
|---|---|
| 0 -7 | indicates sensible or lower risk drinking |
| 8-15 | indicates increasing risk drinking |
| 16-19 | indicates higher risk drinking |
| 20 and over | indicates possible alcohol dependence |

**Please make an appointment with our practice nurse if your score is 8 or more.**

## Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐Polish ☐African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Irish☐Bangladeshi ☐ Chinese

☐ Other (please state):
☐ Decline to state

What is your first spoken language? _____ Do you need an interpreter? Y/N

## Next of kin ……

Name:

Tel. contact number:

Relationship:

## Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐No

## Please tell us about yourself:

**Are you an unpaid carer?** ☐ Yes (918A) ☐No

**Do you have an unpaid carer?** ☐ Yes (918F) ☐No

**If yes,** please tell us the name, address & DOB ofyour Carer or who you care for:

Are you happy for us to contact your carer about you? ☐ Yes ☐No

If you are a Carer, may we pass your details on to Carers in Herts who offer help & support? ☐ Yes ☐No

I give permission for my Carer to have access to my medical records held by the Practice

Signed_____

Date_____

## For patients aged 85 or over ONLY: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐No

In general, do you have any health problems that require you to stay at home? ☐ Yes ☐No

Do you regularly use a stick, walker or wheelchair to get about? ☐ Yes ☐No

In case of need, can you count on someone close to you? ☐ Yes ☐No

Do you need someone to help you on a regular basis? ☐ Yes ☐No

Please provide details if the person is different from the information you have provided as your carer.

| Condition | Year diagnosed | Ongoing |
|---|---|---|
| | | Yes/No |
| | | Yes/No |
| | | Yes/No |

All Patients To Complete, Continued

**By submitting this registration form, you are implying your consent to opt-in for these services. If you do not want to receive the service, use the opt-out forms indicated and return it to reception.**

**Data sharing consent choices ……**

1. NHS England has introduced the **Summary Care Record (SCR)**, which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

   If you wish to **OPT OUT** please complete a SCR Opt-Out form on our website

2. Your mobile number and email address, may be used by the Surgery to contact you for the following reasons:

**Text** - to send you reminders for appointments, vaccinations, annual diabetes reviews, surgery closures etc.

**Email**- to send you personal letters, surgery newsletters and occasional questionnaires.

If you wish to **OPT OUT** please complete a Text/Email Opt-Out form on our website

**Helpful patient information leaflets and opt-out forms can be found at: www.suthergrey.com**

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

**Signature ……..** Date:

Signature of patient ☐ Signature on behalf of patient ☐

## Checklist before coming in to the surgery;

1. Have you completed all relevant sections?
2. Have you signed all relevant sections?
3. Have you completed the GMS1 registration form?
4. Do you have 2 different forms of identification and a copy or your passport?

## Application for access to:

## ONLINE APPOINTMENTS & REPEAT PRESCRIPTIONS

### *Save Time-Do It Online!*

| Surname: | First Name: |
|---|---|
| **Email address:**<br>(To reduce the risk of illegal access to your personal data we recommend using a unique email address) | |

1. **BOOK AND CANCEL YOUR OWN APPOINTMENTS WITH A DOCTOR**
2. **NO NEED TO CALL THE SURGERY**
3. **ONLINE SERVICES ARE AVAILABLE WHEN WE ARE CLOSED**
4. **ORDER A REPEAT PRESCRIPTION**
5. **CONVENIENCE, PRIVACY, FLEXIBILITY**

I wish to access ONLINE SERVICES and agree with each statement (tick)

| | |
|---|---|
| 1. I wish to have access to Online Appointments and Repeat Prescriptions | ☐ |
| 2. I will be responsible for the security of the information that I see or download | ☐ |
| 3. If I choose to share my information with anyone else, this is at my own risk | ☐ |

| Signature | Date |
|---|---|
| | |

As recommended by the Royal College of General Practitioners parental access to a child's record will automatically cease at the age of 11years. The child can then apply for their own account when they reach the age of 16 years.

Please present this form in person at reception; with your PHOTO ID and proof of address (utility bills are not acceptable) and your registration details will be sent to you

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For practice use only

| Name of Staff Member verifying identity: | Date: |
|---|---|
| Verification Method:<br>☐ Personal Vouching ☐ Vouching with information in record<br>☐ Photo ID -<br>Type of photo ID seen: …… | |
| Registration Token Letter printed or emailed: | Date: |
| | |
| **DOCUMENT MUST BE SCANNED AND CODED** | |
| 1st - Read code '91B.. patient data verified' (appts & repeats): | Date: |