# TRINITY MEDICAL CENTRE
# NEW PATIENT REGISTRATION FORM

The information that you provide will be treated in the strictest of confidence. Please take time to read the information attached as to how your information is used and stored.

| PERSONAL DETAILS | | | | | |
|---|---|---|---|---|---|
| **Title** | Mr/Mrs/Ms/Miss<br>Other: | **First Name** | | **Surname** | |
| **Previous Name** | | **Address** | | | |
| **Date of Birth** | | | | | |
| **NHS Number** | | **Postcode** | | | |
| **Home Tel No** | | | | | |
| **Mobile No** | | **Email** | | | |
| **Work Tel No** | | **Sex** | Male | Female | |
| **Town of Birth** | | **Country of Birth** | | | |
| **Ethnicity** (British etc) | | **Main Language spoken** | | | |
| **Do you have a disability?** If yes please state. | | **Do you require an interpreter?** | State language | | |

| EMERGENCY CONTACT DETAILS<br>**This will be the person that the surgery contact in case of emergency** | | | | | |
|---|---|---|---|---|---|
| **Title** | Mr/Mrs/Ms/Miss<br>Other: | **First Name** | | **Surname** | |
| **Home Tel No** | | | | | |
| **Mobile No** | | | | | |
| **Work Tel No** | | | | | |
| **Relationship to you?** | | | | | |
| **Is this person also your next of kin?** | | | | | |
| If you wish for this person to have access to your medical records or access to your appointments, results and other confidential information contact the surgery for further information. | | | | | |

## CARER DETAILS

**(**You are a carer if you spend a significant portion of your time providing paid/unpaid support to another person)
See our website for further information on carers **- www.trinitymedicalcentre.nhs.uk**

| | | |
|---|---|---|
| **Are you a carer?** (if yes please tell us who for (name) and relationship to you) | Yes | No |
| **Do you have a carer?** (if yes please tell us their name and their relationship t o you) | Yes | No |

| PREVIOUS DETAILS | |
|---|---|
| **Previous Home address** | |
| **Previous GP** | |

| If you are from ABROAD | |
|---|---|
| **Date when you arrived from abroad?** | |
| **How long do you intend to stay in the county?** | |
| **You must complete the GMS1 form supplementary questions the receptionist will provide you with this form.** | |

| ARMED FORCES | | |
|---|---|---|
| **Are you currently or have you served in the armed forces in the past?** | Yes | No |
| **If Yes what date did you enlist?** | | |
| **What date did you leave?** | | |
| **Service Number** | | |

## NHS ORGAN DONAR REGISTRATION

***For more information, please visit [www.uktranplant.org.uk](http://www.uktranplant.org.uk) or call 0300 123 23 23***

**I want to register my details on the NHS organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.**

Yes

No

☐ Any of my organs and tissue **or:**

☐ kidneys ☐ heart ☐ liver ☐ corneas ☐ lungs ☐ pancreas ☐ any part of my body

**Please sign and date to confirm consent**

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

## PATIENT REFERENCE GROUP

We meet quarterly at the Surgery and we need a cross section of our patients to join us to help plan services, improve current services and with general issues about the practice as a whole. If you are interested then please tick the box below:
I am interested in being part of the Patient Reference Group and would like more information Yes ☐

## COMMUNICATION PREFERENCE (AIS)

If you require additional assistance when communicating with the practice, please indicate it below by ticking the relevant box. If not, please tick "No additional assistance required)

☐ No additional assistance required. Thank you.

| SIGHT | | SOUND | |
|---|---|---|---|
| Large Print | ☐ | British Sign Language | ☐ |
| Braille (state grade) | ☐ | Audi Cassette Tape | ☐ |
| Other (please state) | ☐ | Other (please state) | ☐ |

**The following questions are about your health in general to assist the doctor whilst we await the arrival of your notes from your previous GP**

| HEALTH INFORMATION | | | |
|---|---|---|---|
| **Smoking status** | Never smoked ☐<br>Current smoker ☐ How many per day…….<br>Ex-smoker ☐ How many per day……. | | |
| **If a current smoker, would you like help to stop smoking?** | Yes | No | If yes our practice HCA will contact you to arrange support. |
| **Height** | | **Weight** | |

| ALCOHOL CONSUMPTION | | | |
|---|---|---|---|
| **Pint beer/lager = 2 units** | **Glass wine = 2 units** | **Single measure spirit = 1 unit** | |
| Do you drink Alcohol? | Yes – Units per week: | | No |
| How often do you have a drink that contains alcohol? Please circle your answer | Never<br>Monthly or Less<br>2-4x per month<br>2-3x per week<br>4+ times per week | Score:<br>0<br>1<br>2<br>3<br>4 | |
| How many standard alcoholic drinks do you have on a typical **day** when you are drinking? | 1-2<br>3-4<br>5-6<br>7-9<br>10+ | Score:<br>0<br>1<br>2<br>3<br>4 | |
| How often do you have 6 or more if female, or 8 or more if male standard drinks on one occasion? | Never<br>Less than monthly<br>Monthly<br>Weekly<br>Daily or almost daily | Score:<br>0<br>1<br>2<br>3<br>4 | |
| **For admin use only – TOTAL AUDIT C SCORE:** | | **/12** | |

| ALLERGIES TO MEDICATION | | | |
|---|---|---|---|
| Do you have an adverse reaction to any medication? | Yes | No | If yes, please list here: |

| FAMILY HISTORY | | |
|---|---|---|
| **Is there a family history of any of the following:** | Diabetes | Yes ☐ No ☐ |
| | Coronary Heart Disease | Yes ☐ No ☐ |
| | Chronic Obstructive Airways Disease | Yes ☐ No ☐ |
| | Asthma | Yes ☐ No ☐ |
| | Hypertension | Yes ☐ No ☐ |
| | Osteoporosis | Yes ☐ No ☐ |
| | If yes please state relationship. | |

Please note that this practice focuses on health education and preventative care and therefore encourages patients to take responsibility for their own healthcare by being up to date with childhood immunisations, cervical smears, bowel and breast screening.

| | | | |
|---|---|---|---|
| **Female patients aged 25-64 only** | **Are you up to date with your cervical smear?** | Yes<br>Please tell us the date of your last smear? | No |
| **Children only** | **Are you up to date with your childhood immunisations?** | Yes | No |
| **Are you currently pregnant?** | Yes<br>No | EDD…….. | |

***CURRENT MEDICATION*** Please list any medication you are currently taking including over the counter medicines including HRT or Contraception

**PLEASE NOTE:** It is the practice policy not to prescribe benzodiazepines and Z-drugs. Patients taking these drugs will only be accepted onto the practice if they agree to enter a reducing programme with the aim to stop.

**CURRENT HEALTH PROBLEMS**

**Do you suffer from or are you on treatment for any of the following**

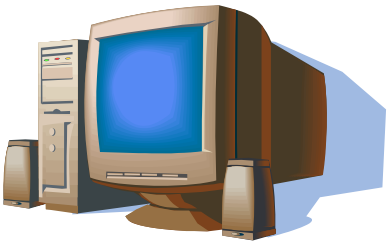
| | |
|---|---|
| Diabetes | Yes ☐ No ☐ |
| Coronary Heart Disease (Heart Problems) | Yes ☐ No ☐ |
| Chronic Obstructive Airways Disease (Chronic Lung Problems | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ |
| Hypertension (High blood pressure) | Yes ☐ No ☐ |
| Epilepsy | Yes ☐ No ☐ |
| Mental Health Problems | Yes ☐ No ☐ |
| Diagnosis of Cancer | Yes ☐ No ☐ |
| Osteoporosis (Brittle Bones) | Yes ☐ No ☐ |
| Previous Stroke | Yes ☐ No ☐ |
| (If yes, date of last stroke……..) | |

**I accept responsibility for my own healthcare working in partnership with the Practice**

**Signed:** **Date:**

| **OFFICE USE ONLY (RECEPTION)** | | | | Initial box when all RECEPTION tasks completed | |
|---|---|---|---|---|---|
| Named accountable GP given to patient | Initials of GP | NOK signature checked | | All sections checked (Y or N) | |
| **OFFICE US ONLY (ADMIN)** | | Initial box when all admin tasks completed | | | |
| **Scanned, Template completed on Emis** | | **Organ Donor coded then passed to Emma** | | **Females (24-65) Cytology checked and passed to HCA.** | |
| **NOK details added** | | **Named GP & Allocated GP coded 67DJ AND 9NN60** | | | |

# Patient Information Leaflet



## DATA PROTECTION ACT – PATIENT INFORMATION

**We take the confidentiality of your personal and medical information very seriously.**

We need to hold personal information about you on our computer system and in paper records to help us to look after your health needs, and your doctor is responsible for their accuracy and safe-keeping. Please help to keep your record up to date by informing us of any changes to your circumstances.

Doctors and staff in the practice have access to your medical records to enable them to do their jobs. From time to time information may be shared with others involved in your care if it is necessary. Anyone with access to your record is properly trained in confidentiality issues and is governed by both a legal and contractual duty to keep your details private.

All information about you is held securely and appropriate safeguards are in place to prevent accidental loss.

In some circumstances we may be required by law to release your details to statutory or other official bodies, for example if a court order is presented, or in the case of public health issues. In other circumstances you may be required to give written consent before information is released – such as for medical reports for insurance, solicitors etc.

To ensure your privacy, we will not disclose information over the telephone or fax unless we are sure that we are talking to you. Information will not be disclosed to family, friends, or spouses unless we have prior written consent, and we do not leave messages with others.

**Data Sharing**

When appropriate, Trinity Medical Centre will share pertinent details of your clinical record between various care professional who are or will be involved in your clinical care (Extended hours GP, local hospitals, district nurses, out of hours services, health visitors, etc). This data is only used for your direct medical care.
You have the option to OPT OUT of these. Please ask the receptionist for further details on how to OPT OUT.

**SMS TEXT messaging service**

We may use SMS messaging to communicate with patient who have provided us with a mobile number, for the purposes of health education/promotion and reminders.

Information sent via an SMS message will be generic and no information which identifies an individual patient such as a name, address, or other items of personal detail will be included. Information stating the reason for the message will be kept to a minimum.