REG CHECKED BY:

DATE :

12 & Over Registration Form

THE KEATS GROUP PRACTICE `

PLEASE COMPLETE IN BLOCK CAPITALS

As it may be some time before we receive your medical records, please complete this form which will provide us with some basic information and help locate your previous medical records
You must also provide: Your NHS Number and Passport also TWO proofs of address (a Bank Statement, Utility bill, Tenancy Agreement) not more than 3 months old.

PERSONAL BACKGROUND INFORMATION

Male ☐ **Female** ☐

Have you ever been treated at this practice before? **Yes** ☐ **No** ☐

Surname: _____ **Forename:** _____

Previous Surname: _____

Calling Name: _____ **Date of Birth:** ____/____/____

Home Telephone No: _____ **Email Address:** _____
(By adding your email address, you are consenting to the Practice communicating with you via email)

10 digits
NHS Number: ☐ ☐☐ ☐☐ ☐☐☐☐ ☐

Work Telephone No: _____

Mobile No: _____

Preferred Contact: Home tel [ ] Work tel [ ] Mobile [ ] Letter to home address [ ]

Email [ ]

If you would like this letter or information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 0203 435 4672 or email keats.group@nhs.net

Are you registered disabled? YES [ ] NO [ ]

If yes please give details of your disability

_____

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Are you a carer for someone? Yes [ ] No [ ]

If "yes" are they registered at the practice? YES [ ] NO [ ]

The name of the person for whom you care _____

Contact number for that person _____

Do you have a carer? Yes [ ] No [ ]

If "yes" are they registered at the practice? YES [ ] NO [ ]

The name of the person who cares for you _____

Contact number for that person _____

For patients <u>aged 75 or over</u>: (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

NEXT OF KIN / EMERGENCY CONTACT

Full Name: _____

Relationship: _____

Contact Telephone No: _____

Address: _____

Is this person your Emergency Contact [ ] and/or Next of Kin

Have you given the above person consent to discuss your record Yes [ ] no [ ]

PATIENT AUTHORITY
CONTACTING YOU

I agree that I may be contacted from time to time, via SMS text messages, with practice News, advice about my health and/or appointment reminders. ☐

LEAVING TELEPHONE MESSAGES FOR YOU

☐ **Yes,** I give consent for the Practice to leave messages on my phone.

☐ **No,** I do not give consent for the Practice to leave messages on my phone.

This consent is to remain in force until further notice of cancellation by me.

Signed:…… Print Full Name……..

YOUR PRESCRIPTIONS

I f you wish for a third party to collect your prescription you will have to give the Practice signed consent.

Please tick the appropriate box:

☐ **Yes**, I give consent for my prescription to be collected.

I would like to nominate the following Pharmacy

☐ **No**, I do not give consent for any 3rd party to collect prescriptions on my behalf.

This consent is to remain in force until further notice of cancellation by me. .

Signed: …… Print Full Name ……

ABOUT YOUR ETHNIC GROUP

To which of these ethnic groups do you feel you belong to? Please tick one box

☐ I do not wish to answer

WHITE

☐ British / Mixed British
☐ Irish
☐ Other

ASIAN

☐ Indian / British Indian
☐ Pakistani / British Pakistani
☐ Bangladeshi / British Bangladeshi
☐ Any other (non-mixed) Asian background,
☐ Please state _____

MIXED

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other (mixed) background,
Please state _____

BLACK

☐ Black British
☐ Caribbean
☐ African
☐ Any other (non-mixed) Black background
please state

OTHER ETHNIC GROUP

☐ Chinese
☐ Vietnamese
☐ North African Arab / Iranian
☐ Arab
☐ Other European (non-mixed),
Please state _____
☐ Other non-European (non-mixed),
please state _____

Please state your country of origin _____

Main Language Spoken _____

Will you need an interpreter? **Yes [ ] No [ ]**

What is your occupation _____

MEDICAL HISTORY

Weight (kg):
Height (cm):
Blood Pressure: Systolic:
Diastolic:

Are you on any regular medication? **Yes [ ] NO [ ]**

If "yes" please make an appointment with reception to see a Clinician.
PLEASE NOTE: Repeat prescriptions will NOT be issued until you have seen a Doctor or Nurse Practitioner

Have you got any Allergies to anything including medications? **YES [ ] NO [ ]**

Any other medical problems, which require medication, or major operation(s):

Please tick "yes" or "no" as to whether you suffer or have suffered from the Following:

	This information is to be filled in about You		
	Yes	No	Date 1st Diagnosed
Heart Disease			
Stroke			
High blood pressure			
Diabetes (please specify) →			**Insulin (Type 1)** **Tablets / Diet controlled (Type2)**
Cancer (please state which type) →			
Asthma or obstructive airways disease			
Epilepsy			

Are you currently a smoker? **Yes [ ] No [ ]**

If "yes" what quantity of cigarettes / cigars or tobacco do you smoke per Day? _____

Have you previously smoked? Yes [ ] No [ ]

If "yes" How many did you smoke per day _____

When did you stop? _____ / _____ / _____
(dd / mm / year)

Advice:
Smoking can cause chronic breathing problems and increase your risk of a heart attack. If you wish to be healthier, and save money, please Tick this box [ ]
And one of our smoking cessation advisors will contact you

WOMEN ONLY

Have you had a smear before? Yes/No

**Date of last cervical (pap) smear: ____ / ____ / _____(dd / mm / year)

Place: Privately* / NHS / Abroad/
****Please provide us with a copy of your last result to include within your medical records.***

Result: Normal [ ] Abnormal [ ]
(Please specify)_____

• Age: 25-49: Invitation 3 yearly (3Y) • Age: 50-64: Invitation 5 yearly (5Y)

OVER 16's ONLY

We are routinely offering HIV tests to all newly registered patients over 16.
Would you like to have an HIV test? Yes/No

FAMILY HISTORY

Please tick "yes" or "no" as to whether a family member suffer or have Suffered from the following:

	This information is to be filled in about your family			Family Member's Relationship to you
	Yes	No	Date 1st Diagnosed	
Heart Disease				
Stroke				
High blood pressure				
Diabetes (please specify) →				
	Insulin (Type 1) **Tablets / Diet controlled (Type2)**			
Cancer (please state which type) →				
Asthma or obstructive airways disease				
Epilepsy				

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

For more information, please ask for a leaflet or visit the website www.uktransplant.org.uk

---

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register *Date*

……..... …../…../……

For more information, please ask for a leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from home address, e.g. your place of work)

…… *Postcode…*

Dear New Patient,

Did you know that 24% of adults drink a hazardous or harmful amount of alcohol? Sadly, many people do not realise that the amount they are drinking has the potential to be harmful.

- This quick questionnaire below can help us to work out if you may be at risk from your alcohol consumption.
- It has been recommended by NICE (the National Institute of Clinical Evidence) to help us find out who may benefit from discussing their alcohol intake further.
- We would like all our new patients to fill this questionnaire out.
- You may wish to look information on Units on the next page below to help you work out how much you are drinking.

Question	**0 points**	**1 point**	**2 points**	**3points**	**4 points**	TOTAL
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 may 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 have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last 6m?	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily	
					TOTAL SCORE	

You may wish to add up your score yourself.

- **If your score is over 5** you may wish to make an appointment with one of the clinicians to discuss this further.
- We will also check the score for you, and **if your score is over 5,** you will be contacted by a clinician to book an appointment to discuss this further.

Please let us know how you would like to be contacted…

a) **By e-mail?** ☐ **Please provide e-mail address here.....**

b) **By post?** ☐

c) **By text?** ☐

Please tick the option you would prefer. You may not be contacted for several weeks.

.

Whatever your score feel free to make an appointment to talk about alcohol further with one of the doctors or nurses

ALCOHOL: Some Tips

Feel free to take this sheet home for your own reference...

What are the benefits of cutting down?

Physical

- Reduced risk of injury
- Reduced risk of high blood pressure
- Reduced risk of cancer
- Reduced risk of liver disease
- Reduced risk of brain damage
- Sleep better
- More energy
- Lose weight / Better physical shape
- No hangovers
- Improved memory

Psychological/Social/Financial

- Improved mood
- Less hassle from family
- Reduced risk of drink driving
- Save money
- Better relationships

What targets should you aim for?

'How to do it' - the ideal

Men
4 or less standard drinks daily
21 or less standard drinks weekly

Women
3 or less standard drinks daily
14 or less standard drinks weekly
No drinks advised during pregnancy

Dependent Drinkers
No drinks are safe

Helpful resources:
Camden Alcohol Service: tel: 02032274950

www.drinkaware.co.uk

www.patient.co.uk/health/Alcohol-and-Sensible-Drinking.htm

www.nhs.uk/Livewell/alcohol/Pages/Alcoholho

Recording Consent of New Patients for Data Sharing Initiatives in Camden

Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care.	I want to: **Opt out** of CIDR. ☐ IF YOU WISH TO OPT OUT OF CIDR PLEASE ASK RECEPTION FOR THE SPECIFIC OPT OUT FORM
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your • medication (last 12m) • bad reactions to medicines • allergies when you're admitted to hospital, when treating you in an emergency, or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐

NHS HEALTHCHECKS

If you are aged between 40 and 74, or if you are south Asian and 30 or over, You are entitled to a free NHS health check
This check is to screen for a number of important conditions, such as Diabetes and hypertension and requires an appointment with our healthcare assistant.

Please tick this box if you are eligible and would like our health care assistant to contact you and arrange a health check. Yes [ ]

Please read the following information

****I agree to the above registration process in full.**

***Signature**:_____

Print: _____ Date: __ / __ / __

For more information you can pick up a practice leaflet or log on to our website. www.keatsgroupractice.nhs.uk

FOR OFFICE USE ONLY

Form checked by

Has the gms1 form been fully completed	YES [ ] NO [ ]
Has the gms1 form been passed to the Patient Services Manager	YES [ ] NO [ ]
Has the Keats information form been checked and fully completed	YES [ ] NO [ ]
Has patient been informed of named GP	YES [ ] NO [ ]
Consent forms have been completed	YES [ ] NO [ ]
Has the patient any access needs	YES [ ] NO [ ]
Has the urine sample been collected	YES [ ] NO [ ]
Has a copy of the practice leaflet be given	YES [ ] NO [ ]

Does the patient wish to be have an appointment for any of the following?

Smoking cessation NHS Health check HIV test

Has the patient completed an application for on line access yes [ ] NO [ ]

Keats Group Practice

Application for online access to my medical record Adults only

Please complete using block letters

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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

1. I have read and understood the information leaflet provided by the practice	☐
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	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

Please note if you have not registered your log-in details online within 3 weeks of issue, they will be invalid and need re-issuing.

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method	Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorized by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled	All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐	Notes / explanation	