Brondesbury Medical Centre

PATIENT REGISTRATION FORM (Adult/Child)

Patient Name:		**Date of Birth:**	
Address & Postcode:			
Telephone Number:		**Mobile Number:**	
Email address*:			
If Child(Father Name)		**Mobile No.**	
If Child(Mother Name)		**Mobile No.**	

Next of Kin – please give details of your next of kin:

Name: _____**Relationship to you:** _____

Mobile Number: _____

We will send you appointment reminders via text and from time to time invite you for any relevant health screening. If you wish to **opt out** of this service please **tick the box** ☐

GP Online Services:

Brondesbury Medical Centre offers all patients' access to GP Online Services. When you register at the practice you will automatically be registered for online appointment booking and repeat prescription requests.

Patient access will give our patients unrivalled ability to book, change or cancel appointments at any time of the day or night.
By using these systems we hope to improve our service to you and also help reduce the pressure on the busy telephone system, making it easier to contact the surgery when you need. You can of course still speak to a receptionist for your appointments but you now have the choice!

Your GP Online Services PIN document will be emailed to you if you have supplied an email address above.

Please tick this box if you would like to **'Opt Out'** of GP Online Services ☐

Registration Questions

As part of the registration process, we would be grateful if you could complete the following questions, where appropriate:

Where were you born? Country:_____ City : _____

To which of these ethnic groups do you belong to?

White	**Mixed**	**Asian or Asian British**
White British ☐	White & Black Caribbean ☐	Indian ☐
White Irish ☐	White & Black African ☐	Pakistani ☐
Any other White background ☐	White & Asian ☐	Bangladeshi ☐
	Any other Mixed background ☐	Any other Asian background ☐
Black or Black British	**Chinese or Any Other Ethnic Category**	**If other category please state:**
Caribbean ☐	Chinese ☐	……
African ☐	Any other Ethnic Category ☐	**I do not wish to answer this question:** ☐
Any other Black background ☐		

Main language spoken? _____**Do you require an interpreter**? | Yes ☐ | No ☐ |

(If you require any further communication support please see page 4)

Are you a Carer? (Please see definition below)

| Yes ☐ | No ☐ | **If Yes please see Page 4**

{Definition of a Carer: A carer is someone who spends time looking after a relative, neighbour or friend who cannot manage on their own because they have a disability, a long term illness, a mental illness or substance misuse problem or they may be frail}

If registering a child:

Is the child one of twins? | Yes ☐ | No ☐ |, **if yes twin number:** _____

What school does your child attend? _____

_____

Health details

Weight:_____ **Height:**_____

How much regular exercise do you do? NONE / LIGHT / MODERATE / HEAVY

Smoking: (please tick the box that is most relevant to you)

| I have never smoked tobacco ☐ | I am currently a non-smoker (*stopped smoking*) ☐ | I currently smoke ☐

If you ticked non-smoker when did you stop? _____

Alcohol Consumption: Please tick your answer to the 3 questions below:

Question	Scoring System				
How often do you have a drink containing alcohol?	**0 Never?**	**1 Monthly or less?**	**2 2-4 time a Month?**	**3 2-3 times a week?**	**4 4 or more times a week?**
How many units of alcohol do you drink on a typical day when you are drinking?	**0 1-2 Units?**	**1 3-4 Units?**	**2 5-6 Units?**	**3 7, 8 or 9 Units?**	**4 10+ Units?**
How often have you had 6 or more units if female, or 8 or more if male on one single occasion?	**0 Never?**	**1 Less than Monthly?**	**2 Monthly?**	**3 Weekly?**	**4 Daily or almost daily?**

What was your total score?_____ How many units of alcohol do you drink in a week?_____ U/Week?

Sexual Health:

We offer free screening for Chlamydia for all 16 - 24 year olds. If you would like to have this test please ask the Health Care assistant or reception for a pack. | Yes ☐ | No ☐ [practice admin PACK GIVEN / DECLINED]

We are offering all newly registered patients an HIV test. Please indicate below if you would like to have this test. If diagnosed in the early stages HIV infection is a treatable disease.

| Yes ☐ | No ☐ If **Yes** Please call us after 1 week to book appointment with our HCA for blood test.

CONDOMS ARE PROVIDED FREE TO MEN AND WOMEN – MAKE AN APPOINTMENT IF YOU WOULD LIKE TO SEE THE PRACTICE FAMILY PLANNING NURSE FOR CONTRACEPTIVE OR FAMILY PLANNING ADVICE.

Past Medical History:

Have you had any serious illness or any serious operations? | Yes ☐ | No ☐ | If yes, please list with dates:

_____

_____

Are you allergic to any tablets or substances? | Yes ☐ | No ☐ | If yes, please list:

_____

_____

Are you currently taking any medications? | Yes ☐ | No ☐ | If yes please list or submit a list:

_____

_____

Smear Test (Women Only)

Have you ever had a cervical smear test? Yes ☐ | No ☐ |If Yes, when was your last test? _____

Was it normal? | Yes ☐ | No ☐ | If No, when & where is your follow up _____

Please give brief details _____

Family History:

Is there any disease history in your family? | Yes ☐ | No ☐ | If yes, please tick the box and write relation

Problem	Family member	Problem	Family member
Epilepsy ☐		Blood pressure ☐	
Diabetes ☐		Heart attack ☐	
Blindness/glaucoma ☐		Sudden death ☐	
Asthma ☐		Thyroid problems ☐	
Hay fever ☐		Mental illness ☐	
Eczema ☐		Cancer (if yes, of which part of the body?) ☐	
Stroke ☐			

Would you like to join Brondesbury Medical Centre's Patient Participation Group? Yes ☐ | No ☐

(For more information please speak to one of the reception)

To be completed if you have specific communication needs

Communication Support

If you struggle to complete this form, please ask a member of staff to help you.

Name:_____ Date of Birth:_____

Do you consent for this information to be shared with other health & social care organisations?
Yes ☐ | No ☐

Do you need an interpreter? Yes ☐ | No ☐ If yes, what Language:_____

Are you visually impaired? Yes ☐ | No ☐

Would you benefit from any on the following: Braille ☐ | Large Print ☐ | Audio Tape ☐
(please note that our system doesn't allow this at present, however capturing the information will help us plan future developments)

Deafness: Yes ☐ | No Other:_____

If you have a difficulty communicating, which is your preferred method of communication?

Home telephone number	☐	Letter to home address	☐
Work telephone number	☐	Letter to temporary address	☐
Mobile telephone number	☐	Fax	☐
Email address	☐	Video Conference*	☐

*(*please note that our system doesn't allow this at present, however capturing the information will help us plan future developments)*

Do you have any other communication need we should know about? Please Describe?

Carer Information

(i) Are you a carer for someone? Yes ☐ | No ☐
If yes, are they registered at this practice? Yes ☐ | No ☐

Name of the person you care for _____

Contact Number _____

(ii) Do you have a Carer? Yes ☐ | No ☐
If yes, are they registered at this practice? Yes ☐ | No ☐

Name of the person who cares for you or the care agency:
_____

Their contact number _____

Please ask for a Carers Pack from reception

Please note: the information you give will be treated confidentially and is subject to the Data Protection Act.

DATA SHARING

Please read and make your selection by ticking the box or boxes next to the right statement. Then please fill out the required information below, sign and date the form and return it to reception.

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. **PLEASE READ ATTACHED INFO**	I want to: Opt **IN** to CIDR. ☐ Opt **OUT** of CIDR. ☐ **IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM ATTACHED.** **ADMIN – do not code opt out.**
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.	I want to have a Summery Care Record ☐ I ***DO NOT*** want to have A Summery Care Record ☐

Name: _____ Signature: _____

Date of Birth: _____ Date: _____

If you **DO NOT** want a CIDR Record or to share the information with specific organisations, please fill out the details overleaf and hand it into the reception who will action your request.

OPT OUT FORM

Please complete ALL sections in Part A and Part B.

Part A: Personal Details

Please complete in BLOCK CAPITALS for the relevant Service User / Patient.

Title:		**NHS Number:**	
Forename:			
Surname:			
Address:			
Postcode:		**Date of Birth:**	

Part B: Opt-Out of CIDR

(Please tick)

I do not consent to have a CIDR record created. ☐

I confirm that I understand the impact of this request.

Signed:		**Date:**	

PLEASE HAND BACK TO THE RECEPTIONIST ON COMPLETION

OFFICE USE ONLY: On completion, please email Page 2 of this form (this page) to CIDR.Records@nhs.net