New Patient Registration Form

PATIENT INFORMATION			
Surname:		Forenames:	
Date of Birth:	/ /		
Address:			
Postcode:			

Home telephone number:	Mobile telephone number:	Work telephone number:

Preferred contact telephone number: ❑ Home ❑ Mobile ❑ Work ❑ Other_____

Next of Kin:	Relationship of next of kin:
	Telephone number of next of kin:

Do you require the assistance of an interpreter? ❑ Yes ❑ No
If yes, please indicate which language you require:

Are you a military veteran? ❑ Yes ❑ No (You may be eligible for priority care)
Please see our website for further information: www.lindenmedical.co.uk

If registering a minor (under 18 years), please provide details of school/College currently attending

Name of School/College:	
Address:	
Postcode:	

Do you look after someone? Or Does someone look after you?

The practice is trying to identify and support as many Carers (unpaid) as we can. This includes helping a family member, friend or neighbour because of their physical, mental ill health, frailty, learning disability or substance misuse with tasks such as helping with cooking/cleaning, taking to appointments, collecting prescriptions, administering medication and any other support related tasks.

Yes I am a Carer ☐ No I am not a Carer ☐
Someone cares for me ☐ Name: _____

Registering as a Carer with us will entitle you to a free annual flu vaccination and annual health check as well as giving you access to lots of other free support and services.

Please ask reception for a Carers Pack

FAMILY HISTORY (IF KNOWN)

	If living, present age	State of health	If deceased, age at date of death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Have any members of your family suffered from diabetes, high blood pressure, mental disorder, heart disease, kidney trouble, cancer, bowel disease or stroke?

❑ Yes ❑ No If yes, please give details:_____

Do you have, or have you ever had a Social Worker involved with your family? ❑ Yes ❑ No

MEDICAL HISTORY QUESTIONNAIRE

Have you ever sought medical advice or received treatment for any of the following:

	Yes	No	Please give details
Anaemia/abnormal bleeding problem			
Respiratory problem			
Heart murmur/heart surgery			
High/low blood pressure/stroke			
Liver problems or jaundice			
Kidney problems			
Diabetes			
Epilepsy/blackouts or fainting			
Immunosuppressive disorders			

Any known allergies? ❑ Yes ❑ No If yes, please give details: _____

Are you pregnant? ❑ Yes ❑ No If yes, please indicate EDD: _____

	Never smoked	Ex-smoker	Smoker
Smoking status:			

	Light	Moderate	Heavy
Weekly exercise:			

Height:	
Weight:	
Blood pressure reading:	

Please inform us of anything that you feel is medically necessary:

Do you have any special communication needs? _____

Are you happy for us to share this information with other healthcare providers? ❑ Yes ❑ No

For office use:

Driving licence/passport/utility bill, other _____

Please state which identification documents have been checked _____

Checked by:	Staff name:	Staff signature:	Date:
Checked by:	Staff name:	Staff signature:	Date:

Linden Medical Group

Patient Consent/Dissent for Email and Text Message Communication

Linden Medical Group wishes to improve its communications with patients by adding the use of email. This service will not be active immediately, however we hope that in the near future these services will be available. It is with this in mind that we are now starting to gain consent/dissent for this service, so that when the service becomes available, you are able to have access to it straightaway.

Patient privacy is important to us, and Linden Medical Group would like to communicate with you regarding activities that may be of interest, which means that we need your consent.

This may include using emails and the use of text messaging to send patients reminders about the details of their next appointment and other appropriate matters relating to your care and healthcare services offered by the practice.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used as a first contact method for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by asking at reception for a dissent form. Your contact details will not be passed to any commercial organisations for any purpose.

Please complete this form and hand it in at reception if you consent/dissent to any, or all, of the above.

I understand that it is my responsibility to let Linden Medical Group know as soon as possible if I change my mobile telephone number and/or email address.

Please tick the options below which apply to you.

Text messages □ I **consent** to receiving text message reminders for appointment times and other appropriate matters relating to my care. □ I **do not** wish to receive text message reminders for appointment times and other appropriate matters relating to my care.
Emails □ I **consent** to receiving emails in relation to healthcare services offered by the practice. □ I **do not** wish to receive emails in relation to healthcare services offered by the practice.
Name:
Date of birth:
Mobile phone number:
Email address:

Signature:	Date:

Please help us by providing information about your ethnic group

Why we are collecting information about your ethnic group?

Everyone belongs to an ethnic group, so all of our patients are being asked to describe their ethnic group. We are collecting this information to help the NHS and Social Services to:

- **Understand the needs** of patients and service users from different groups and so provide better and more appropriate services for you
- **Identify risk factors-** some groups are more at risk of specific diseases and care needs, so ethnic group data can help treat patients and support services users by alerting staff to high-risk groups.
- **Improve public health** by making sure that our services are reaching all of our local communities and that we are delivering our services fairly to everyone who needs them.
- **Comply with the Law** as the Race Relations (Amendment) Act 2000 gives public authorities a duty to promote race equality and good race relations, and ethnic monitoring is important in making sure that the race discrimination is not taking place.
- The 16 ethnic groups used are standard categories for collecting ethnic group information. Using these codes will help us to compare information about the groups using our services with information from the census which tells us about our local population.

The list of groups is designed to allow most people to identify themselves. The list is not intended to leave out any groups of people but to keep the collection of ethnic information simple. It is important to us that you are able to describe your own ethnic group.

If you need to complete any of the boxes labelled' any other group', then please give some details so that we can better understand your needs.

You do not have to complete the question but providing this information is very important. It will help us with diagnosis and assessment of your needs and it will also help us to plan and improve our service. The information you provide will be treated as part of your confidential NHS record. The NHS and Social Services have strict standards regarding Data Protection and your information will be carefully safeguarded.

If you have any concerns or questions regarding this request or want to make any comments or complaints about the collection of this information or the way in which you have been treated by staff requesting this information please contact the Practice Manager.

The Department of Health has asked us to record the ethnic origin of all new patients

This information will be added to your medical record.

If you do not wish to provide this information, please tick the information refused box at the end of the list.

Name	
Date of birth	

Ethnic Origin

Please tick the description which you feel is most appropriate

White - British	
White - Irish	
Other White background	
Mixed – White and Black Caribbean	
Mixed – White and Black African	
Mixed – White and Asian	
Other Mixed background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Other Asian background	
Black or Black British – Caribbean	
Black or Black British - African	
Other Black background	
Chinese	
Other ethnic background	
Information refused	

AUDIT - C

Name: _____

Please tick the applicable boxes below.

	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often do you have a drink containing alcohol?					

	1 – 2	3 – 4	5 – 6	7 – 9	10+
How many units of alcohol do you drink on a typical day when you are drinking?					

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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?					

For office use:

Scoring

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT – C positive.

Scoring system	0	1	2	3	4

Linden Medical Group Online Patient Participation Group registration form

Would you be interested in being part of a virtual community of Linden Medical Group Patients, whose views and opinions can help shape the future of services provided by this practice?

The Patient Participation Group at Linden Medical Group has been in existence for a number of years and the virtual group is simply an extension, which will hopefully reach out into the wider patient population.

By joining the Online Patient Participation Group, you will receive updates on any changes to services or procedures and from time to time, be invited to complete questionnaires to help the Practice understand if different or additional services should be considered in the future.

To join you will need to be a registered patient here at Linden Medical Group, have a current email address and access to the Internet. Simply complete the registration form below and overleaf and await further details. Please note that your email address will only be used for Patient Participation Group purposes. Your email address will not be linked to your medical records.

Name:	
Date of birth:	
Email address:	

I confirm that I am a registered patient at Linden Medical Group and I consent to my email address being stored for the purpose of the Linden Medical Group Virtual Patient Participation Group.

Signed:	
Date:	

Please provide the following information by ticking the relevant boxes.
This information will only be used to monitor the demographic make-up of the Patient Participation Group.

Male	Female

	17-24	25-34	35-44	45-54	55-64	65-74	75-84	Over 85
Age Group:								

Ethnic Background

White British	White Irish	White/ Black Caribbean	White/ Black African	White/ Asian	Indian	Pakistani	Bangladeshi	Caribbean	African	Chinese	Other

	Regularly	Occasionally	Very Rarely
Frequency of visits to the Practice:			

Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ……..….....

Date of birth: …… Patient's postcode: ……

Surgery name: …… Surgery location (Town): …….....

NHS number (if known): ……..…….....

Signature: ……. Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …….....

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6