

REGISTRATION FORM
PLEASE WRITE CLEARLY AND COMPLETE ALL RELEVANT BOXES

Title	
Surname	
First Name(s)	
Previous Surname(s)	
Date of Birth	
Precise Town, County & Country Of Birth	
Male or Female	
Home Address	
Postcode	
Telephone Number	
Mobile Number	
NHS Number (If Known)	

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION:

Your previous address in UK, including postcode	
Name of Doctor while at this Address	
Address of previous Doctor	

IF YOU ARE FROM ABROAD

Your first UK address where registered with a GP, including postcode	
Date you first came to live in UK	
Date you expect to be leaving UK (if known)	
If previously resident in UK, date of leaving	

IF YOU ARE RETURNING FROM THE ARMED FORCES

Address before enlisting, including postcode	
Service or Personnel Number	
Enlistment Date	
Discharge Date	

**If you are registering a child under 5:
I wish the child above to be registered with the named
doctor for Child Health Surveillance**

Yes / No Please circle your answer

Signature of Patient:	Date:
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ETHNIC CATEGORY AND FIRST LANGUAGE QUESTIONNAIRE

As part of our registration process all new patients are asked to complete this questionnaire.

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

ETHNIC CATEGORY

Please indicate your ethnic category. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

This form may only be completed by the patient in person, or a parent in the case of a child. It may not be changed by us unless you ask for a change. This information will be added to your computer health record and will remain confidential.

Choose ONE section from A to F, and then tick ONE box to indicate your background. If asked to specify, please do so as fully as possible. If you do not wish to enter your ethnic category please go straight to section F.

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please write in below

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please write below

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please write below

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other black background please write below

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other please write below

F Not Stated

<input type="checkbox"/>	If you do not wish to state your ethnic origin please place a \checkmark in the box below.
<input type="checkbox"/>	

FIRST LANGUAGE MONITORING

Please indicate which is your **first** language by placing a tick in the relevant box below:

	Tick Here		Tick Here
012 English		030 Korean	
001 Akan (Ashanti)		031 Kurdish	
002 Albanian		032 Lingala	
003 Amharic		033 Luganda	
004 Arabic		034 Makaton (sign language)	
005 Bengali & Sylheti		035 Malayalam	
006 Brawa & Somali		036 Mandarin	
007 British Signing Language		037 Norwegian	
008 Cantonese		038 Pashto (Pushtoo)	
009 Cantonese & Vietnamese		039 Patois	
010 Creole		040 Polish	
011 Dutch		041 Portuguese	
013 Ethiopian		042 Punjabi	
014 Farsi (Persian)		043 Russian	
015 Finnish		044 Serbian/Croatian	
016 Flemish		045 Sinhala	
017 French		046 Somali	
018 French creole		048 Spanish	
019 Gaelic		049 Swahili	
020 German		050 Swedish	
021 Greek		051 Sylheti	
022 Gujarati		052 Tagalog (Filipino)	
023 Hakka		053 Tamil	
024 Hausa		054 Thai	
025 Hebrew		055 Tigrinya	
026 Hindi		056 Turkish	
027 Igbo (Ibo)		057 Urdu	
028 Italian		058 Vietnamese	
029 Japanese		059 Welsh	
		060 Yoruba	
		200 Other	

YOUR FULL NAME: DATE OF BIRTH:.....
 (Please use capital letters)

Your signature.....

ADDITIONAL INFORMATION

NHS ORGAN AND BLOOD DONOR REGISTRATION FORM

Name	
Date of Birth	
Home Address Including post code	
Telephone Number	
Mobile Number	
NHS Number (If Known)	

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 as appropriate:

Kidneys		Heart		Liver		Corneas	
Lungs		Pancreas		Any part of my body			

Signature confirming consent to organ donation

.....Date.....
 (For more information, please ask for the leaflet on joining NHS Organ Donor Register)

NHS BLOOD DONOR REGISTER

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 the leaflet on joining NHS Blood Donor Register)

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

.....Postcode.....

HEALTH QUESTIONNAIRE

Please complete this questionnaire as fully as possible. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It can take several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

PERSONAL DETAILS	
Surname:	First name(s):
Previous surname(s):	Sex: Male/female Title: Mr/Mrs/Miss/Ms/Dr/Other
Date of birth:	Occupation:
Home address:	
Home tel:	Mobile tel:
Work tel:	Email:

NEXT OF KIN	
Name:	Telephone:

CHILDREN UNDER 18
Name of school currently attending:
Name of responsible adult: (<i>responsible adult is the natural mother or parents if married at time of birth, or an individual given legal custody</i>)

WOMEN ONLY	
Date of last cervical smear:	
Result:	
Have you had a hysterectomy?	

HEALTH INFORMATION	
Height:	Weight:
Do you smoke? Yes/no Cigarettes/cigars/pipe/roll-ups	If yes, how many per day?
Have you ever smoked? Yes/no	If you have stopped smoking, give approximate date you stopped:
<i>We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of our smoking cessation services.</i>	
Do you have any allergies? animals/pollen/nuts/medication/other (please specify)	
Have you ever suffered from a bad reaction to any medication? Yes/no If yes, please give details:	
What medication do you currently take? (include both prescription and over the counter, please attach a previous repeat medication slip if you have one):	

What regular exercise do you take?

PERSONAL & FAMILY MEDICAL HISTORY

Have any close relatives (parents, brothers, sisters or children) suffered from any of the following. or died before the age of 65? Please specify the disease and their relationship to you.

Diabetes?

Heart Attack (under 55) ?

Stroke?

Asthma ?

Cancer ?

Please give details of any serious illnesses you have suffered including dates:

ARE YOU A CARER?

A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.

YES / NO (Please circle as appropriate)

Please provide the following details for the person you care for:

Name:

Date of Birth:

Your relationship to this person:

Please note if you answer yes to this question you will be added to the Practice Carers Register. We have a dedicated Carers Lead in the practice who can offer advice and support. Please ask at reception.

UNITS



Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

ALCOHOL QUESTIONNAIRE

PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

PLEASE CHECK THAT YOU HAVE SIGNED THE FORMS ON PAGES 1,3 AND 4 BEFORE HANDING BACK TO THE RECEPTIONIST.

IT IS ALSO IMPORTANT THAT YOU READ PAGE 8

Dorset 

Primary Care Trust
Dorset Primary Care Trust
Hillfort House
Poundbury Road
Dorchester
DT1 2PN

Dear Patient

Your Summary Care Record

I am pleased to tell you that your GP Practice has now introduced the Summary Care Record.

What is the Summary Care Record?

The Summary Care Record is an electronic record of important information about your health. It will be available to staff of organisations providing your NHS care, first locally here in Dorset and later anywhere in England.

This means that if you have an accident or fall ill, the people treating you will have immediate access to important information about you, helping them to provide you with safer, better care.

Accessing Your Record – Enhanced Security With New Consent Model

If a healthcare professional needs to view your Summary Care Record, your permission will be asked beforehand, unless you are unable to communicate your wishes at the point of care.

How Will it be Developed?

At the moment your Summary Care Record only contains details of allergies, recent prescriptions and previous bad reactions to medicines. We now plan to add more information about your health to your Summary Care Record.

What Type of Information May Now be Added?

To start with, important information on any problems or conditions you may have, such as:

- **Significant illnesses and health problems from the past, such as a heart attack;**
- **Illnesses that you take regular medication for, such as asthma or diabetes.**

Further types of information that may be added in the future are:

- Important test results;
- Immunisations;
- Information you might have given your GP about how you want to be treated in an emergency, such as not wanting a blood transfusion.

If there is any information that you do NOT want to be included in your Summary Care Record, you must let your GP know.

How Will Sharing the Additional Information Benefit Me?

By including more information in your Summary Care Record:

- Healthcare professionals treating you, who have no other clinical records about you, will have a more complete picture of your healthcare needs. This is especially important if you have a long-term condition such as asthma or diabetes;
- More information means that better and quicker decisions can be made about your care.

What if I Don't Want a Summary Care Record?

If you don't want a Summary Care Record and you have already told your GP Practice, you don't need to do anything else. If however, after reading this letter you decide not to have a Summary Care Record please ask for a form from your practice, or visit the following website:

www.dorset-pct.nhs.uk/health_services/electronic_health_services/summary_care_record

Once you have registered with this GP Practice it will be assumed you are happy to have a Summary Care Record unless you have already opted out or take steps to opt out as detailed above.

In addition, Dorset patients over 16 can register to access their Summary Care Record via an advanced account on a secure website called HealthSpace. If you wish to open an advanced HealthSpace account you will need to first register online. Register at <http://www.healthspace.nhs.uk> for both a basic account and advanced account by completing both forms online then email the PCT at healthspace@dorset-pct.nhs.uk for further information.

I hope this has been helpful and I would like to thank you for your support in taking forward this important and exciting development.

Yours sincerely

Paul Sly
Chief Executive