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| Trinity Logo | Trinity Surgery |  |
|  | 29 St Augustines Road |
|  | Wisbech, Cambs, PE13 3UZ |
|  | Tel: 01945 476999 |

**New Patient Registration Questionnaire aged 16 and over**

**Before your registration appointment please make sure you have fully completed this questionnaire. THERE MAY BE A DELAY IN YOUR REGISTRATION WITHOUT THESE DOCUMENTS**

|  |  |
| --- | --- |
| Patient check list (tick below ) | |
| Photographic identification (photo driving license card or passport |  |
| Your NHS number which you can obtain from your previous doctors surgery |  |
| If you are taking regular medication please ensure you obtain 1 month’s medication from your previous surgery to allow us time to add your medication to your notes. You **must** also bring a copy of your repeat prescription with this form. |  |
| Any vaccination records you may have |  |
| Urine sample (please write your name and date of birth on the bottle) |  |
| Blood pressure reading (this can be done in the surgery waiting room please arrive 5 minutes before your appointment time and take your blood pressure. |  |

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| Title\* | Mr  | Mrs  | Miss  | MS | | Other –*please specify* | | | | | | |
| Full name :\* | | | | | | | | | | | | |
| Date of birth:\* | | DD/MM/YYYY | | Gender | | | Male \* | | Female \* | | Other –*please specify* | |
| Address: \* | | | | | | | | | | | | |
| Post code:\* | | | | | | | | | | | | |
| **Preferred Mobile telephone number: \***  **We will use this number to send appointment reminders & information texts to your mobile phone. Please tick here if you give your consent for this. \*** | | | | | | | | | | | | |
| Preferred Home phone number : | | | | | | | | | | | | |
| Email Address: | | | | | | | | | | | | |
| *IF APPLICABLE – CARE HOME REGISTRATIONS\**  Is this address for-  Residential Care? Yes No  Nursing Care? Yes No | | | | | | | | Next of Kin name: \* | | | | |
| Contact details: \* | | | | |
| Relationship to you:\* | | | | |
| **Have you ever served in the British Armed Forces** ? | | | | | | | | | | | | |
| Army  **** | | Military  **** | | | Royal Air force  **** | | | | | Royal Marines **** | | Royal Navy  **** |

**FOR OFFICE USE ONLY:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Height & weight | BP & Pulse | ID x 1 | Sharing | Regular medication. If yes do not accept without repeat prescription | | Smoking offered | Urine sample | Nominated pharmacy | Date | Registration letter given | | Online details given | |
|  |  |  |  | **Y ** | **N ** |  |  |  |  | **Y ** | **N ** | **Y ** | **N ** |

**Information about you and your medical history**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please record your blood pressure, pulse, height and weight** | | | | | | | | |
| **Height\*** | **Weight \*** | | | **Blood pressure\***  **Pulse \*** | | | | |
| **Please tell us about the type of work you do:\*** | | | | | | | | |
| **Country of Birth:\*** | | | | Main language spoken:\* | | | Interpreter required. Yes  No | |
| **Do you have any allergies? Yes No \*** | | | | If yes what are your allergies? | | | | |
| **Do you take regular exercise? E.g. 20min brisk walking**,  1/2/3 times per week?\* Yes  No | | | | If no why is that ? | | | | |
| **Do you smoke?** \* Yes No Ex-Smoker  If yes how many per day - | | | | Please note if you want to stop smoking we offer a stop smoking service Would like an appointment in this clinic  Yes No If yes a link to book stop smoking appointment will be sent to your mobile phone. | | | | |
| **\*Alcohol consumption – please complete below:** | | | | | | | | |
| Q1. How often do you have a drink containing alcohol? | | | Q2. How many units of alcohol do you drink on a typical day when you are drinking? | | | Q3. How often do you have 6 or more units (if female) or 8 or more units (if male) on a single occasion? | | |
| Never | |  | 1or 2 | |  | Never | |  |
| Monthly or less | |  | 3 or 4 | |  | Less than monthly | |  |
| 2-4 times a month | |  | 5 or 6 | |  | Monthly | |  |
| 2-3 times a week | |  | 7 or 8 | |  | Weekly | |  |
| 4 or more times a week | |  | 10 or more | |  | Daily or almost daily | |  |
| Please note if your declared alcohol consumption is above the recommended limit, you will be invited to discuss this further with one of our clinicians. | | | | | | | | |
| **\*Female patients only**  All ladies between the age of 25 and 65 are routinely offered a cervical screening (smear test pap smear) every 3-5 years. Please answer the questions below.  \*What was the date of your last cervical screening? :  \*If you are due for your cervical screening would you like to book an appointment? Yes No if yes a link to book your cervical screening will be sent to your mobile phone. | | | | | | | | |
| **Are you a carer?**  Yes  No  If yes, we would like to be able to support you and highlight that you are a recognised carer  Please tell us who you are for and your relationship to them?  Name: Relationship to you? | | | | | | | | |

**Ease of access due to disability/impairment/sensory loss**

Please tick if you have any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Sight impairment | Hearing impairment | Disability | Other\* |

Please select your preferred method of contact:

|  |  |  |  |
| --- | --- | --- | --- |
| Letter | E-mail | Telephone Call | SMS Message |
| Other\* - Please state: | | | |

All of this information will remain completely confidential and will not be used for any other purpose

**Have you recently entered the country as refugee?** Yes  No

If you answer yes to this question you will be offered an appointment with a nurse for additional screening

**TB Symptom Checker for people coming from Ukraine**

**Patient Name: Patient D.O.B:**

For children aged over 11 and (non-pregnant) adults.

Please tick the boxes if you have any of the symptoms listed below;

* Lack of appetite and weight loss
* A high temperature
* Night sweats
* Extreme tiredness or fatigue
* A persistent cough that lasts more than 3 weeks and usually brings up phlegm, which may be bloody.
* Breathlessness that gradually gets worse
* Any new swelling around the neck

**We also ask for proof of any vaccinations you may have had. Please include these with your completed registration forms. These will be added to your record and our nurses can make sure you are all up to date.**

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| **Please indicate the Ethnic group to which you feel you belong:\***  **White**   * British * Irish * Any white background   **Mixed**   * White and Black Caribbean * White and Black African * White and Asian * Any other mixed background   **Asian or Asian British**   * Indian * Pakistani * Bangladeshi | * Chinese * Any other Asian background   **Black or Black British**   * Caribbean * African * Any other black background   **Other Ethnic Groups**   * Arab * Any other ethnic group |

**Sharing of information and your health record**

Information about your health and care help the NHS to improve your individual care, speed up diagnosis, plan your local services and research new treatments.

\*Share out- Will you consent to share your medical record with any other health care provider involved in your care Yes  No

\*Share in- Will you consent to Trinity Surgery viewing information in your medical record recorded by other health care services? Yes  No

**Summary Care Record – your emergency care summary**

The NHS in England introduced the Summary Care Record to be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you to have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice:

\*Yes I would like a Summary Care Record – You do not need to do anything and a summary care record will be created for you.

\*No I do not want a Summary Care Record – Please ask reception for a Summary Care Opt Out form, complete it and return to the surgery.

**Nominated pharmacy**

All prescriptions will be sent electronically to your nominated pharmacy. Please indicate your preference. This can be changed at any time.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Well | Boots Horsefair | Boots Walsoken | Boots Dehavailind Road | Tesco | Asda | Fairbrothers | Other |
|  |  |  |  |  |  |  |  |

**Online access**

All patients are offered an online account.

|  |  |  |
| --- | --- | --- |
| I would like an online account. | Yes | No |

Please bring proof of residence to create an online account. Your online account will give you access to book & cancel appointments, view your medical records including test results.

**Zero tolerance**

Trinity Surgery supports the government’s ‘Zero Tolerance’ campaign for Health Service Staff. This states that GPs and their staff have a right to care for others without fear of being attacked or abused. To successfully provide these services a mutual respect between all the staff and patients has to be in place.

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| --- | --- | --- |
| Have you been registered to the special allocation scheme due to unacceptable behaviour? | Yes | No |