# The Consulting Rooms
# New Patient Registration Form

**Today's Date:**

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring photographic identification to confirm your date of birth and also a utility bill or housing agreement for proof of address and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Full Name:** | | | | | **Telephone Number:** | |
| **Mr / Mrs / Miss / Ms / Other……..** | | | | | **Work Number** | |
| **Address and Postcode** | | | | | **Mobile Number:** | |
| | | | | | **E-mail Address:** | |
| | | | | | **Next of Kin:** | |
| | | | | | **Next of Kin Contact Number:** | |
| **Date of Birth:** | | **Previous / Mother's surname if different:** | | | **Town & Country of Birth** | |
| **Marital Status:** | | **Gender:** | **Male:** | **Female:** | **Other residents of your home:** | |
| **Occupation:** | | | | | | |
| **Names & Ages of Children** | | | | | | |
| **Housing (Select one)** | **House** | **Maisonette** | **Flat** | **Mobile Home** | **NHS Number (If Known)** | |
| **Previous Address** | | | | | **Previous Postcode:** | |
| | | | | | **Previous Doctor Telephone No.** | |
| **Previous Doctor Name & Address:** | | | | | **Previous data released?** | **Yes** / **No** |
| | | | | | **If applicable, date you first came to live in Britain:** | |
| **If returning from Armed Forces:** | | **Your Service or Personnel Number** | | | **Your Enlistment Date** | |
| **Your height:** | **Feet / inches** | **cm** | **Your weight:** | | **Stones / lbs.** | **kg** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Your Religion:** | **C of E** | **Catholic** | **Other Christian (state)** | **Buddhist** | **Hindu** | **Muslim** |
| | **Sikh** | **Jewish** | **Jehovah's Witness** | **No religion** | **Other religion (state)** | |

| Your Ethnic Origin: (select one) | White (UK) 9i0 | White (Irish) 9i1% | White (Other) 9i2% |
|---|---|---|---|
| Caribbean 9i3 | African 9i4 | Asian 9i5 | Other Mixed Background 9i6% |
| Indian / Brit Indian 9i7 | Pakistani / Brit Pakistani 9i8 | Bangladeshi / Brit Bangladeshi 9i9 | Other Asian Background 9iA% |
| Other Black Background | Chinese 9iE | Other 9iF% | Ethnic Category not stated 9iG |

| Your main or 1st language Spoken / Understood: (select one) | | English | Hindi | Gujurati | Urdu | Bengali /Sytheti | Punjabi |
|---|---|---|---|---|---|---|---|
| Polish | Ukrainian | French | German | Spanish | Other: (Please Specify) | | |

**Smoking, Alcohol Consumption and Exercise:**

| Are you currently a smoker? | Yes | No | Have you ever been a smoker? | Yes | No |
|---|---|---|---|---|---|
| If Yes do you want help to stop? | Yes | No | | | |
| If so, how many cigarettes / cigars / tobacco do you smoke in a week? | | | How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)* | | |
| *If you are a smoker and want to stop, please ask for information about local smoking cessation services.* | | | | | |

| How often do you exercise? | No. times per week | Type(s) of exercise: | |
|---|---|---|---|

**Your Medical Background:**

| What illnesses have you had & When? | |
|---|---|
| What operations have you had and When? | |
| Do you have any medical problems at present? | |
| Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency) | |

| Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply) | Diabetes | Heart Attack | Heart attack under age of 60 | Bowel Cancer | |
|---|---|---|---|---|---|
| | Breast Cancer | | High Blood Pressure | Asthma | Stroke |
| | Thyroid Disorder | | Any other important Family Illness? | | |

| What immunisations have you had? (please put the date you had for all that apply) | Diphtheria | Measles | German Measles | Tetanus | Polio | MMR |
|---|---|---|---|---|---|---|
| | Whooping Cough | | Pre-school booster | Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses | | |

| **Specific Needs:**<br>**Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** | | |
|---|---|---|
| **Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):** | | |
| **Are you an 'Assistance Dog' User?** | | |
| **Please state any Physical disabilities you have:** | | |
| **Please state any Mental disabilities you have:** | | |
| **Please state any requirements you have to be able to access the Practice premises** | | |
| **Please state any Religious or Cultural needs:** | | |
| **Do you require the help of a Translator / Interpreter?** | | |
| **Please state any specific nutritional requirements you have:** | | |
| **Please state any allergies and sensitivities you have:** | | |
| **Please state any phobias you have:** | | |
| **If you are a Carer, please state the name / address / phone number of the person you care for:** | **Person Cared For Contact Details:** | |
| **If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.** | **Carer Contact Details:** | |
| | **Signed:** | **Date:** |
| **Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?** | **Yes / No** | ***If "Yes", can you please bring a written copy of it to your New Patient Consultation*** |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | **Yes / No** | **If "Yes", please state their name / address / phone number:** |

| Women only: | | | | |
|---|---|---|---|---|
| When was your last smear done? | Date | Was this at your GP's Surgery? | Yes | NO |
| What was the result of the smear? | | | | |
| Date of last mammogram (if applicable): | Date | Method of contraception (if used): | | |
| Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)? | | | Yes | NO |

**Summary Care Records.**

**The NHS are changing the way your health information is stored and managed.**
**The NHS Summary Care record is an electronic record of important information about your health.**
**It will be available to health care staff providing your NHS Care. An information pack has been provided.**

| Are you happy to have a Summary Care Record? | Yes | No | More Time Required to decide: |
|---|---|---|---|

**Patient Participation Group**

**The Practice is committed to improving the services we provide to our patients.**
**To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.**
**By expressing your interest, you will be helping us to plan ways of involving patients that suit you.**
**It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.**
**If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.**

| Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box) | Yes |
|---|---|

| Patient Signature: | | Signature on behalf of Patient: | |
|---|---|---|---|

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

## Thank you for completing this form

***For more information about the services we offer, please refer to your new patient pack or see our website: www.theconsultingroomssouthoxhey.co.uk***

# The Consulting Rooms

# *If you're a Carer who helps and supports someone who can't manage on their own, we want to ensure YOU get all the support YOU need.*

To be able to do this, we need to know certain facts about your caring situation, as listed in the form overleaf.

Please complete this form and either hand it to our Receptionist or place it in the special "Carers Referrals" box in Reception.

If you are agreeable, we will pass your details to the Carers Service, a countywide organisation providing relevant information and advice, local support services, newsletter and telephone linkline for carers.

With your permission, we will also refer you to have your needs assessed by Adult Care Services. This is called a Carers' Needs Assessment.

There is no charge for this, and it's your chance to discuss your role as a Carer and what help you may need to:

- Support you as a Carer,
- Maintain your own health
- Balance caring with other aspects of your life, like work and family, looking at both your current and future needs.

It's NOT about judging the way you are caring for someone, nor should social services assume that you wish to become, or carry on being, a carer.

As a result of completing the Assessment, the local authority may provide services to help you in your caring role or to maintain your own health and well-being.

It can also look at the needs of the person you care for. This could be done separately, or together, depending on the situation.

# The Consulting Rooms

## Carer's Identification and Referral Form

**YOUR DETAILS**

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | Date of Birth | |
| | | Home Phone | |
| Post Code | | Mobile Phone | |
| Any relevant information | | | |

**DETAILS OF THE PERSON YOU LOOK AFTER**

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | Date of Birth | |
| | | Home Phone (If different) | |
| Post Code | | Mobile Phone (If different) | |
| GP details (If different) | | | |

☐ Please pass my details to the Carer's Service

☐ Please refer me to Adult Care Services for a Carer's Needs Assessment

Signed:_____

***Please complete this form and hand it to our Receptionists***

# *Thank you for completing this form*

Office Use Only

This form needs to be sent to:
Carers service = Carers in Herts, 22a High Street, Hemel Hempstead, Herts, HP2 3AE
Or
Adult Care Services = The Carers Coordinator, Adult Care Services, Apsley one, London Road, Hemel Hempstead, Hp3 9xy