Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……………………….

LARGE PRINT

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Sex: ☐ Male ☐ Female

Date of Birth (day/month/year)

NHS Number

Town & Country of Birth

Post Code:

Address

Telephone number:

Mobile number:

ONLINE ACCESS

As a practice we are now using "patient access" meaning you can book appointments and order prescriptions anytime, anywhere. To join you will need to follow the instructions attached and provide us with your email address.

☐ Yes I would like to register

Email address:

NHS Organ Donor registration:

Organ Donation Law changed in England on 20th May 2020

What has changed? Organ donation in England has moved to an 'opt out' system. You may also hear it referred to as 'Max and Keira's Law'. This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups:-

- Those under the age of 18
- People who lack the mental capacity to understand the new arrangements and take the necessary action
- Visitors to England, and those not living here voluntarily
- People who have lived in England for less than 12 months before their death

Your family will still be approached and your faith, beliefs and culture will continue to be respected. You still have a choice whether or not you wish to become a donor.

If you wish to opt out of organ donation you will need to visit https://www.organdonation.nhs.uk/register-your-decision or ring 03001232323

NHS Blood Donor registration:

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 to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

…………………………………………………. Post code: ………………….

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No

Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any <u>close relatives</u> (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack Under age of 65	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

Please provide us with your repeat medication card or Prescription counterfoil. If you do not have a prescription counterfoil, we can try to obtain this information by accessing your Summary Care Record (SCR). Please tick this box if you consent to us accessing your SCR for this purpose ☐

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No

If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐ Pipe

Are you an ex-smoker? ☐ Yes ☐ No

When did you give up?

How many cigarettes/ Cigars do you smoke daily? ☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like help to quit smoking? ☐ Yes ☐ No

Would you like help to quit smoking? ☐ Yes ☐ No

if yes please contact reception to see Counsellor
https://www.nhs.uk/smokefree

Lifestyle alcohol ……

Do you drink alcohol: ☐ Yes ☐ No

If yes, please answer the following questions:

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 ☐ Weekly ☐ Daily or almost daily

Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean
☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Other (please state):
☐ Decline to state

Next of kin ……

Name:

Tel. contact number:

Relationship:

Where you have provided information on how to contact you, can you confirm you are happy for Bodriggy Health Centre to contact you by the following:

By email ☐ Yes ☐ No This will be to send you, test results letters, newsletter and the like

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text and test results

Preferred method of contact Text message ☐ Email ☐

Summary Care Record

A Summary Care Record (SCR) is an electronic patient record, a summary of National Health Service patient data held on a central database covering England, part of the NHS National Programme for IT.

Only authorised healthcare staff with appropriate level of security are able to access your Summary Care Record

Tick the following relevant boxes:-

Express consent for medical, allergies, adverse reactions, AND additional information ☐

The additional information is not yet active as yet but by ticking the above box you are giving consent in readiness

Express dissent (opted out) –

you do not want a Summary Care Record ☐

If you wish to OPT OUT from having your clinical information being held on this database please ask at reception for an OPT OUT form.

Signature ……

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: ______________________ Date: __________

Signature on behalf of patient ☐ Signature of patient ☐

Updated 27.05.2020