Patient informed of Registered GP
Name of Registered GP

When completed please post this form or hand it in to: Sleaford Medical Group, 47 Boston Road, Sleaford, NG34 7HD
OR
Submit via the practice website: www.sleafordmedicalgroup.co.uk/medical-forms

NEW PATIENT REGISTRATION

Please complete in **BLOCK** Capitals with as much information as possible.

TITLE	MR ☐	MRS ☐	MISS ☐	MS ☐	OTHER (please state)	
SURNAME						
FIRST NAMES						
ANY PREVIOUS NAMES						
TOWN AND COUNTRY OF BIRTH						
NHS NUMBER (if known)						
DATE OF BIRTH						
GENDER	MALE ☐	FEMALE ☐	OTHER (please state)			
HOME ADDRESS POSTCODE						

HOME TELEPHONE		
MOBILE TELEPHONE		
Is the telephone number above owned by the patient being registered if not please state who?		
It is the responsibility of the registered patient to keep your details up to date. Patients over the age of 12 are legally entitled to have their own number registered.		
Do you consent for the practice to contact you by SMS text message?	YES ☐	NO ☐
Do you consent for the practice to contact you via email	YES ☐	NO ☐
Email Address		

IF YOU HAVE MOVED FROM OVERSEAS – THE DATE YOU ENTERED THE UK.	
IF YOU HAVE AN EHIC CARD, PLEASE STATE THE IDENTIFICATION NUMBER.	

The following information is required to allow us to trace your medical records.	
PREVIOUS ADDRESS IN UK POSTCODE	
NAME AND ADDRESS OF PREVIOUS GP	

Rec Ints		Disp		Date	

* Staff to code details on to records.

If you are Ex Armed Forces:			
ADDRESS BEFORE ENLISTING POSTCODE			
Enlistment Date		Discharge Date	

WOULD YOU LIKE A NEW PATIENT HEALTH CHECK	YES ☐		NO ☐
SMOKING STATUS	NEVER SMOKED ☐	EX SMOKER ☐	SMOKER ☐
IF YES TO 'SMOKER', HOW MANY PER DAY?			
WOULD YOU LIKE HELP TO STOP SMOKING	YES ☐		NO ☐
YOUR HEIGHT			
YOUR WEIGHT			
ARE YOU A CARER?	YES ☐		NO ☐
DO YOU HAVE A CARER?	YES ☐		NO ☐
ENGLISH SPEAKER	YES ☐		NO ☐
MAIN LANGUAGE SPOKEN			
ARE YOU INTERESTED IN REGISTERING FOR ONLINE SERVICES?	YES ☐		NO ☐

ETHNICITY – How would you describe your ethnicity?					
White	British ☐	Irish ☐	Other White ☐		
Asian	Asian British ☐	Bangladeshi ☐	Indian ☐	Pakistani ☐	Other Asian ☐
Black	Black British ☐	African ☐	Caribbean ☐	Other Black ☐	
Mixed	Asian & White ☐	Asian & Black ☐	Asian & Caribbean ☐	White African ☐	White Caribbean ☐
Other	Chinese ☐	Japanese ☐	Middle Eastern ☐	Turkish ☐	Any other ethnicity ☐

Please provide the Practice with any further information you feel will benefit your care for example: Do you suffer with Mental Health problems? Are you hearing/sight impaired? Are you a Veteran? Do you have any known allergies?*

NHS Sharing: Please make your choice below

Choice One – NHS Summary Care Record (SCR)

This is your own choice about how you would like to share your health record:

I would like core information from my health record at Sleaford Medical Group to be available for other healthcare services providing care for me to view with my full consent	**YES** ☐	**NO** ☐
I would like core and additional information from my health record at Sleaford Medical Group to be available for other healthcare services providing care for me to view with my full consent	**YES** ☐	**NO** ☐

Please Note: You may change your preference at any time by completing an opt out form

Choice Two – Enhanced Data Sharing Module (EDSM)

SHARING OUT: I would like my health record at Sleaford Medical Group to be available for other healthcare services providing care for me to view with my full consent	**YES** ☐	**NO** ☐
SHARING IN: I would like Sleaford Medical Group to be able to view the information in my health record that has been recorded by other services	**YES** ☐	**NO** ☐

Please Note: You may change your preference at any time by completing Consent for Record Sharing form.

Name:_____

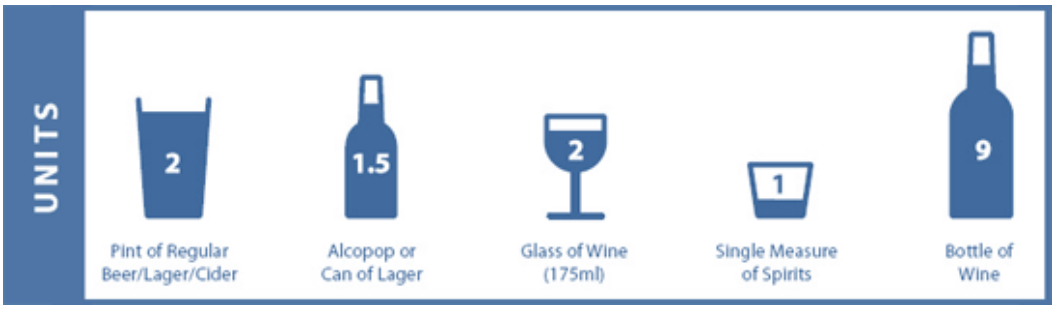
Signature: _____Date:_____

***Online Access: If you wish to register for Online Services this can only be done after your application for registration is complete which is up to 48 hours. If you wish to register for this service you need to attend the surgery with Photo ID.**

ALCOHOL QUESTIONNAIRE

For the following questions please circle the answer which best applies to your drinking in the last year.

Declined to complete Alcohol screening test questionnaire. ☐



1.	**MEN:** How often do you have 8 or more drinks on one occasion? **WOMEN:** How often do you have 6 or more drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
2.	How often during the last year have you not been able to remember the night before because you had been drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
3.	How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
4.	Has a relative, friend, Doctor or other health worker been concerned about your drinking or suggested you cut down?	No ☐	Yes, but not in the last year ☐	Yes, during the last year ☐	- ☐	- ☐
5.	How often do you have a drink that contains alcohol?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
6.	How many standard alcoholic drinks do you have on a typical day when you are drinking? (please circle)	1-2 ☐	3-4 ☐	5-6 ☐	7-8 ☐	10+ ☐
7.	How often do you have 6 or more standard drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
8.	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/Almost daily ☐
9.	*See question 3*					
10.	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/Almost daily ☐
11.	How often in the last year have you had a feeling of guilt or regret after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/Almost daily ☐
12.	*See question 2*					
13.	Have you or someone else been injured as a result of drinking?	No ☐	Yes, but not in the last year ☐	Yes, during the last year ☐	- ☐	- ☐
14.	*See question 4*					

Your Choice-Your Record

With so many choices to make about sharing your information how can you be sure you are making the correct choices for you and your dependents?

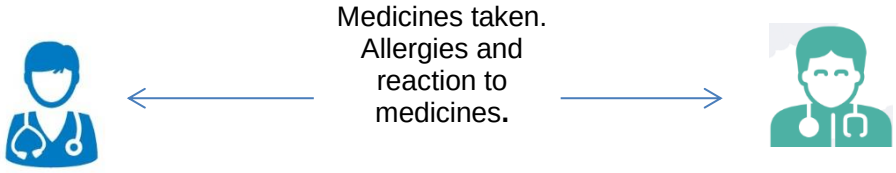
This leaflet aims to explain the differences between the options available, ensuring you can make a considered, informed choice. We have also included the relevant consent/dissent forms, please read these carefully before your preference and returning them to the Reception.

Choice 1 - NHS Summary Care Record (SCR)

Core Information - A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had, no other medical information is held in the record. Having this information stored in one place makes it easier for healthcare staff will have access to this record.

Core & additional Information- An Enriched Summary Care Record includes additional information such as details of long term conditions, significant medical history, or specific communications needs.

Example: You have a fall and are unconscious, an ambulance is called to take you to hospital; there is nobody with you that knows your medical history. When you get to the hospital the Doctor decides you need some medicine, how does he know if the one he is about to give you will cause an allergic reaction? If you have said YES to share your record the Doctor will have instant access to this information and will be able to treat you accordingly. If you say NO this could delay treatment whilst this information is requested from your GP.



Choice 2 – Enhanced Data Sharing Module (EDSM) - The clinical computer system used at Sleaford Medical Group is System One. This system is widely used in this area and across England. The system gives us a facility (EDSM) to share your health record with other health providers involved in your care. Your health record includes your medical history, medication history and any allergies you may have. You can now choose whether to share these full medical details with other health provider units (for example the District Nurses). Many organisations may use System One including some GP practices, out of hour's services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.
You have two choices which allow you to control how your record is shared. You can change these choices at any time by completing a consent form.

Sharing OUT: This controls whether your information recorded at this practice can be shared with other health care providers.

Sharing IN: This determines whether or not this practice can view information in your record that has been entered by other services who are providing care for you or who may provide care for you in the future.

Example: Imagine you are receiving care from your GP, a district nurse and a smoking clinic. You want your GP and district nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However, you don't want the smoking clinic to see any of your other medical information.

PATIENT CONSENT TO SHARE RESTRICTED ACCESS

Patients Details (The person whose records another individual is to be granted access)	
Surname	
First Name	
Date of Birth	
NHS Number	
Gender	
Address Postcode	
Contact Telephone Number	
Details of the person who will have restricted access	
Full Name	
Address Postcode	
Contact Telephone Number	

Please Note: Identification will need to be provided by the patient upon application. Sleaford Medical Group must be able to verify consent and signature from the patient.

Give consent to the person named above to act on my behalf for: (Please Tick)	**YES**	**NO**
Collect Blood/Urine/X-Ray Request Forms & Results	☐	☐
Collect Sick Notes	☐	☐
Collect Prescriptions from Reception	☐	☐
Discuss my continuing medical care with my GP	☐	☐

Signed: _____ Dated: _____

!! ID Check_____

This will remain on your records unless you notify the surgery that you wish for it to be removed.

Rec Ints		Date	