

FOR RECEPTION USE ONLY		FOR RECEPTION USE ONLY	
EMIS NUMBER:		Family members	
REGISTERED GP:		Appointment booked with GP	
PHOTO ID VERIFIED:			
PROOF OF ADDRESS:		ADULT REGISTRATION FORM	

<p style="text-align: center;">PAVILION SURGERY 2-3 Old Steine, Brighton, BN1 1EJ https://www.pavilionsurgery.co.uk/</p>
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<p style="text-align: center;"><i>Supplying this information gives consent for us to contact you where medically necessary</i></p> <p style="text-align: center;">Please confirm we have your permission to telephone, text or email you regarding your direct care (please circle):</p> <p style="text-align: center;">YES NO</p>

Title: <i>(Mr, Miss, Mrs, Ms, Mx, Dr, other)</i>	
Name:	
Date of Birth	
Sex assigned at birth: <i>We ask for your assigned sex to help us screen for sex- specific diseases such as cervical/prostate cancer</i>	Male Female Prefer not to say
Do you identify with a different gender to your birth gender? Pronouns:	Yes / No <i>Eg. She/her, They/them, He/Him</i>

Ethnicity

Asian British	Mixed White & Asian	Other :
Black African	Mixed white & Black African	Prefer Not to Say
Black British	Mixed white & Black Caribbean	White Other
Black Caribbean	Other Asian Background	White British

Height		
Weight		
<p>Family History:</p> <p>Do you have any illnesses in your family?</p> <p><i>Such as cancer, heart disease, diabetes, ect.</i></p> <p>Please include family member & health condition</p>		
<p>Allergies/side effects:</p> <p><i>(Such as allergic reactions to medications, bee stings, foods, etc..)</i></p>		
<p>Do you have, or have you had, any serious health problems (including operations) or long term conditions?</p> <p><i>If YES please include details & dates:</i></p>	Yes/No	
<p>Do you consider yourself to have a disability:</p> <p><i>If YES please give brief details</i></p>	Yes/ No/ Prefer not to say	
<p>Smoking status:</p> <p><i>If YES, how many per day:</i></p> <p><i>If EX SMOKER, when did you quit:</i></p>	<p>Yes / No / Ex-smoker</p> <p>(We offer Smoking Cessation appointments with our nurses)</p>	

Are you being prescribed medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO , Please skip this page
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Medication For example: Aspirin	Dose For Example: 75mg once daily	Reason for medication For Example: "I had a stroke"

Which pharmacy would you like your prescriptions sent to:	
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Please book a face to face appointment with your new doctor before you ask for any prescriptions or medications.

**If you are going to run out of medication,
ask your previous GP surgery for a prescription.**

Please note we prescribe according to national guidelines.

Painkillers including Gabapentin and Pregabalin

We do not prescribe opiates or gabapentinoids for long term pain. This includes codeine, tramadol, zopain, dihydro-codeine, gabapentin and pregabalin. If you are taking these drugs for long term pain, we will prescribe a reducing course of these drugs and stop them.

Sleeping tablets.

We do not prescribe long term benzodiazepines for sleep problems.

This includes zopiclone, zolpidem and temazepam.

If you are taking these drugs, we will prescribe a reducing course of these drugs and stop them.

Benzodiazepines

We do not prescribe long term benzodiazepines. This includes diazepam. If you are taking these drugs, we will prescribe a reducing course of these drugs and stop them.

Please sign here to say you have read and understood this page

Signature _____ Name _____ Date _____

What is your main spoken language:	
Do you have any special communication requirements: <i>(Eg. Use of interpreter, receiving letters in large print, ect)</i>	
<p>Summary Care Record</p> <p>A Summary Care Record is used in Emergency Care. It contains information about your medicines, allergies & bad reactions to drugs to ensure your carers have enough information to treat you safely.</p>	<p>Your Summary Care Record will be available to Authorised staff providing your care in England & will ask permission to look at it.</p> <p>Should there be an accident or illness Healthcare Staff will have immediate access to important information about your health.</p> <p>A Summary Care Record will automatically be created for you unless you wish to opt out.</p> <p><i>If you do wish to opt out, please indicate here:</i></p> <p>Opt OUT</p> <p><input type="checkbox"/></p>
<p>This will help medical staff care for you properly, and respect your choices, when you need care away from your GP practice. This is because having more information on your SCR means they will have a better understanding of your needs and preferences. When you are treated away from your usual doctor's surgery, the health care staff there can't see your GP medical records. Looking at your SCR can speed up your care and make sure you are given the right medicines and treatment.</p> <p>The only people who might see your Summary Care Record are registered and regulated healthcare professionals, for example doctors, nurses, paramedics, pharmacists and staff working under their direct supervision. Your Summary Care record will only be accessed so a healthcare professional can give you individual care. Staff working for organisations that do not provide direct care are not able to view your Summary Care Record.</p> <p>Before accessing a Summary Care Record healthcare staff will always ask your permission to view it, unless it is a medical emergency and you are unable to give permission.</p>	

Emergency Contact details <i>(someone we can contact if medically necessary)</i>	
Relationship status: <i>e.g. Mother, Father, Spouse, friend, flat mate,...</i>	
Title And Full Name: <i>(Mr, Miss, Mrs, Ms, Mx, Dr, other)</i>	
Address:	
Mobile Number:	
Home Telephone Number:	
Are they registered as a patient at Pavilion Surgery?	Yes / No
<p>Would you like the above person to : Make appointments ?</p> <div style="text-align: center;"> <input type="checkbox"/> </div> <p>Speak about medical records ?</p> <div style="text-align: center;"> <input type="checkbox"/> </div>	
Have you served in the armed forces: If YES please provide details:	Yes/No
Are you a carer: <i>Do family, friends or neighbours rely on you because they have long-term ill health, disability or problems with old age</i> If YES would you like to be sent an information pack about help available to you?	Yes/No Yes/No

Application for online access to my medical record (OVER 16's ONLY)

A higher standard of documentation is needed for online registration. You will need two forms of documentation, one of which must contain a photo. Acceptable documents include passports, photo driving licences and bank statements, but not bills (see

Full Name:	
Confirm Email:	
Confirm Mobile:	

I wish to have access to the following services (please tick all that apply):

1. I have read and understood the information leaflet provided by the practice. <i>(Available at the ground floor reception)</i>	
2. I will be responsible for the security of the information that I see or download.	
3. If I choose to share my information with anyone else, this is at my own risk.	
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
Signature:	Date:

Things to consider

Forgotten history

There may be something you have forgotten about in your record that you might find upsetting.

Abnormal results or bad news

If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. If this happens please contact your surgery as soon as possible. The practice may set your record so that certain details are not displayed online. For example, they may do this with test results that you might find worrying until they have had an opportunity to discuss the information with you.

Choosing to share your information with someone

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure. If it would be helpful to you, you can ask the practice to provide another set of login details to your Online services for another person to act on your behalf. They would be able to book appointments or order repeat prescriptions. They may be able to see your record to help with your healthcare if you wish. Tell your practice what access you would like them to have.

Coercion

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

Misunderstood information

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

Information about someone else

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	



Scoring:

A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.

If your score is higher than 8 and would like **Free NHS Help** for alcohol problems please call the Surgery on 01273 685588 or contact: www.changegrowlive.org.uk who offer a drop-in service at:

Richmond House,
 Richmond Road,
 Brighton BN2 3FT
 Tel: 01273 731 900

Mon-Tues-wed-Fri 9am-5pm/Thursday 9am-7pm & Saturday 10am-1pm.