!S07BACK

## A B B E Y

MEDICAL CENTRE

63 Central Avenue

Beeston

Nottingham

NG9 2QP

Dr D Cavangh

## A B B E Y

MEDICAL CENTRE

63 Central Avenue

Beeston

Nottingham

NG9 2QP

Dr Clements

Telephone: (0115) 9255323

Dear New Patient,

Welcome to Abbey Medical Centre, this practice accepts patients who have moved into, or are living in, our catchment area. If you unsure you can use the NHS website in the Find a GP section. If you would then like to register with us, then you will need to fill in the following paperwork within this registration pack. Once this paperwork is complete you can bring this back in person to reception or email it over to

[nnicb-nn.c84065a@nhs.net](mailto:nnicb-nn.c84065a@nhs.net) .

Ensure you read the documents carefully and fill in all pages including consent and Summary Care record to ensure your application is completed fully, failure to do so will lead to us having to contact you to come back and complete the missing information.

Yours sincerely

Dr Cavanagh and Partners

\*\* Our Patient Participation Group meets every 3 months to provide a channel of communication between the practice staff and patients, to break down barriers and to provide practical support to the surgery. If you wish to become a member or would like more information, please contact Ms Joy Stevenson our Deputy Manager. \*\*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Patient Details** | | | | | | | | | | | |
| **NHS No.** |  | | | | | **Town & Country of Birth** | |  | | | |
| **First** **Name** |  | | | | | **Surname** | |  | | | |
| **Known as** | *(if different from first name)* | | | | | **Date of Birth:** | |  | | | |
| **Gender** | Male  Female  Indeterminate  Unspecified / Unknown | | | | | | | | | | |
| **Marital Status**: | Single  Married  Divorced  Co-habiting  Separated  Widowed | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Ethnicity** | **White** | | **Black, African, Caribbean or Black British** | | | **Asian / Asian British** | | | **Mixed or Multiple ethnic groups** | | |
| English, Welsh, Scottish, Northern Irish or British  Irish  Gypsy or Irish Traveller  Any other White background | | African  Caribbean  Any other Black, African or Caribbean background | | | Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background | | | White and Black Caribbean  White and Black African  White and Asian  Any other Mixed or Multiple ethnic background | | |
| **Other Ethnic group** | | |
| Other: | | | | | | | | Arab  Any other ethnic group | | |
|  | | | | | | | | | | | |
| **Employment**  **Status** | Employed | | **Occupation:** | | | | | | | | |
| Self-employed | | Employed / Paid Carer | | | | Unemployed | | Retired | | |
| **Are you a Military Veteran?** | | | Yes  No | **Family Member in Military?** | | | | | | Yes  No | |
| **Are you an Asylum seeker?** | | | Yes  No |  | | | | | |  | |
|  | | | | | | | | | | | |
| **Language** |  | | | **Interpreter Needed** | | | | | | | Yes  No |
|  | | | | | | | | | | | |
| **Religion** | C of E | Buddhist | | Sikh | | | | | No religion | | |
| Catholic | Hindu | | Jewish | | | | | Other: | | |
| Other Christian | Muslim | | Jehovah’s Witness | | | | |  | | |
|  | | | | | | | | | | | |
| **Housing** | Own Home | Rented Home | | | Supported Home | | | | Temporary Housing | | |
| Homeless | No Fixed Abode | | | In Care | | | | Refugee | | |
| Other: |  | | | | | | | | | |
| Live Alone | Live with Family | | | Live with Children | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Contact Details & Address** | | | | | | **Preferred** |
| **Home Phone** |  | | | | |  |
| **Mobile Phone** |  | | | | |  |
| **Work Phone** |  | | | | |  |
| **E-mail** |  | | | | | |
| **Skype ID** |  | | | | | |
| **Consent** | If you give us a mobile and/or email we will assume you are happy for us to contact you using them. If you are **NOT** happy to be contacted this way please tick the box : | | | | | |
| **Current Address** |  | | | | **Postcode** | |
|  | |
| **Address Type** | Home | Temporary | Correspondence Only | Other: | | |

|  |  |
| --- | --- |
| 1. **Family, Relationship & Emergency Contact Details** | |
| **Next of Kin Name & Number** |  |
| **Names & Ages of Children** |  |
| **Other individuals in your household** |  |
| **Emergency Contact/s**  *(name, number & relationship)* |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Carer Details** | | | | | | | | | |
| Do ***you*** have a carer who *you* are **dependent on** for some or all of the time? | | | | | | | | | Yes  (has a carer)  No |
| **Name of Person** |  | | | **Patient at this practice?** | | | | | Yes  No |
| **Relationship to you** | Child (young carer) | | Relative | | | Other: | | | |
| **Type of** Carer | Informal | | Paid | | | Parent | Other: | | |
| Carer **Address**  *(if different to yours)* |  | | | | | | | | |
| Carer **Home Phone Number** |  | | | | Carer **Mobile Phone Number** | | | |  |
| Carer **Email Address** |  | | | | **Does the carer hold a care plan for you?** | | | | Yes  No |
| **I am happy for you to share my health care record / information with my carer :** | | | | | | | | | Yes  No |
| **Would you like information on support services for carers?** | | | | | | | | | Yes  No |
|  | | | | | | | | | |
| Are ***you*** a carer who **looks after someone** else dependent on you for some or all of the time? | | | | | | | | | Yes  (is a carer)  No |
| **Relationship to you** | | Friend  Neighbour  Relative  Other: | | | | | | | |
| **Their Condition** | | Physical Disability | Mental Health Problem | | | | | Terminal Illness | |
| Learning Disability | Chronic Disease | | | | | Sensory Impairment | |
| Dementia | Alcohol Misuse | | | | | Other: | |
| Substance Misuse | Elderly | | | | |
| **Would you like information on support services for carers?** | | | | | | | | | Yes  No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Accessible Information Needs** | | | | |
| **Condition / Issue** | Registered  Blind | Registered  Deaf | Other: | |
| **When we speak to you** | British Sign Language | Lip reader | Hearing aid | Other: |
| **When we write to you** | Braille | Large print | Easy read | Other: |
| **Preferred Contact Method** | Telephone | Text message | Post | Other: Email |
| **Other Communication Needs** |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Your Medical Information** | | | | | | | | | | | | | | | | | | | | | |
| **Height** |  | | | | | | | | | **Weight** | | | |  | | | | | | | |
| **Alcohol Consumption** | | | | | | |  | | | | | | | | | | | | | | |
| How often do you have a drink containing alcohol? | | | | | | | Never | | | | Monthly or Less | | | | 2-4 times per month | | | 2-3 times per week | | | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? (see below) | | | | | | | 1-2 | | | | 3-4 | | | | 5-6 | | | 7-9 | | | 10+ |
| 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 |
| Image result for alcohol units | | | | | | | | | | | | | | | | | | | | | |
| **Smoking Status** | | Never  Smoked | | Ex  Smoker | | | | Light Smoker  <10 day | | | | Moderate  Smoker  11-19 a day | | | | | Heavy  Smoker  >20 a day | | | Vaping | |
| **Diet** | | Good | | | Average | | | | | | | | Poor | | | | | |  | | |
| **Exercise** | | Heavy | | | Moderate | | | | | | | | Light | | | | | | No Exercise | | |
| **Have you ever or are currently suffering from any of the following conditions?** | | | | | | | | | | | | | | | | | | | | | |
| Arthritis  Asthma  Autoimmune Disease  COPD  CVA | | | Dementia  Depression  Diabetes  Epilepsy  Heart Failure | | | Hypertension  Heart Disorder  Kidney Disease  Liver Disease  Peptic Ulcer Disease | | | | | | | | | | Thyroid Disorder  Stroke  Cancer  - Please specify below: | | | | | |
| Any other relevant past medical history | | | | | | | | | Previous operations / surgical procedures | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | |
| Previous hospital admissions | | | | | | | | | Currently being seen at a hospital clinic | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | |
| Are you allergic to any medications? | | | | | | | | | Any other allergies? e.g. animals, dust | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | |
| **Nominated Pharmacy for Electronic Prescriptions (EPS)**  If your prescriptions go directly to a pharmacist and you want us to add this to your record, then please let us know the name and address below:  **Name of pharmacy:**  **Address of pharmacy** | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Your Family History** | | | | |
| Please tell us about any important family history of close relatives with medical problems and confirm which relative e.g. Mother, Father , Grandparent or Sibling (brother or sister) | | | | |
| **Condition** (tick all that apply) | **Which relative?** | | **Condition** (tick all that apply) | **Which relative?** |
| Arthritis |  | | Heart Failure |  |
| Asthma |  | | Hypertension |  |
| Autoimmune Disease |  | | Heart Disease |  |
| COPD |  | | Kidney Disease |  |
| Cardiovascular Problem |  | | Liver Disease |  |
| Dementia |  | | Peptic Ulcer Disease |  |
| Depression |  | | Thyroid Disorder |  |
| Diabetes |  | | Stroke |  |
| Epilepsy |  | | Cancer |  |
| **Other relevant family history not listed above:** | | |  | |
| **6a. Women Only** | | | | |
| Do you use any contraception? | | Yes  No  If needed, please book appointment. | | |
| Are you currently pregnant? | | Yes  No  Expected due date: dd / mm /yyyy | | |
| Date of last smear test | | dd / mm /yyyy | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Signatures** | | | |
| I confirm that the information I have provided above is true to the best of my knowledge. | | | |
| **Signature** |  | | |
| Signed by patient | Signed on behalf of patient | |
| **Name** |  | **Date** |  |

**Consent Form**

|  |  |
| --- | --- |
| Forename: |  |
| Surname: |  |
| DOB: |  |

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors’ surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

**\*\*Please delete as appropriate below to inform us of your consent preference\*\***

**Share-out**

**I would\* / would-not\*** like the information recorded at Abbey Medical Centre to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

**Share-in**

**I would\* / would-not\*** like the information recorded at other care teams who are involved in my care to be seen by members of the team at Abbey Medical Centre, where I have granted those care teams the right to add to my shared data.

I understand that I can change my decision at any time.

Signed (Patient for patient representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Summary Care Record**

**Your emergency care summary**

Your Summary Care Record is used in emergency care. This record contains 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 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 you 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. The additional information includes significant medical history, reasons for medication, communication preferences and immunisations.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

**What does it mean if I DO NOT have a Summary Care Record?**

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

|  |  |
| --- | --- |
| **Forename** |  |
| **Surname** |  |
| **Date of Birth** |  |
| **Signature** |  |
| **If not signed by patient, please confirm relationship to patient.** |  |

**Please circle YES or NO**

I would like a summary care record  **YES/ NO**

I would like a summary care record with additional information **YES/NO**

I do not want a summary care record  **YES/NO**

Actioned by practice yes/no Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_