### **Welcome to Torridon Road Medical Practice**

### **New Patient Application Form**

Before registering please check with reception that you live in our catchment area.

Registration times are 9:30am - 6:00pm & Registration takes 3 - 5 working days :-

#### Please bring :-

- 1. Practice Registration Form & completed New Patient Questionnaire Children under 16yrs should have sections a,b,c,d completed
- 2. Recent proof of address in our catchment area for everyone who is 16yrs & over e.g. utility bill, bank statement (dated within last 3 months)
- 3. Child's Red Book if under 5 years old

### a) Online Appointment Booking

A limited number of appointments can be booked **online** and you can also order prescriptions online.

Photo ID & Bank Statement/Utility Bill must be provided If you wish to use this facility

please tick in the box 🗸

After 3 -5 working days you can Collect Your ID No. & Password from the Surgery



#### **NEW PATIENT QUESTIONNAIRE**

**b) Please complete the following questionnaire.** This enables you to advise us of important aspects in respect of your health. All information will be included in your medical record and will be treated with the strictest confidentiality.

Surname/Family Name		First Name(s)						
Address		Date Of Birth						
Telephone Number		. NHS No. (if know	NHS No. (if known)					
Mobile Number		. Work Telephone	Work Telephone					
E-mail Address		. Child's School	Child's School					
Do you live alone? Yes / N	o Do you have any co	mmunication requiren	nents? Audio / Braille / Large Font					
Next of Kin/Carer		. Relationship	Relationship					
andline No	Mobile No	E-mail						
c) Ethnicity and Social	<u>History</u>							
	ctice, we treat all patients equally e offer to patients. The following in		, ethnicity or social group. We constantly is. All information is confidential.					
White  □White British □White Irish □Other White Ethnic Group □Black, other non-mixed origin □Black British		<b>Asian</b> □Indian □Pakistani □Chinese	□Any other ethnic group					
Please State	□Black N African/Arab/Iranian □Black - Other Asian	Prefer not to say	d) Use of your GP Medical Data					
What is your first language?			Stop your care data leaving     GP Practice .(9NU0)					
e) <u>Lifestyle</u> Do you smoke ? –		YES/NO ?	OR					
If Yes NO. OF CIG	ARETTES DAILY ?		2. Allow your data to leave your GP but stop your care data leaving the HSCIC (9NU4)					
If Yes	have you ever smoked?	YES / NO ?	OR  3. If you consent to your data being used by HSCIC please tick					
			Yes I consent					

# f) The Alcohol Users Disorders Identification Test

Do you drink alcohol?

Yes / No

If Yes, please complete the Alcohol Users Disorders Identification Test, below

# **The Alcohol Users Disorders Identification Test Shortened AUDIT Questionnaires**

How often do you have a drink containing alcohol?

(2) 2-4 tim (3) 2-3 tim	ly or less nes a month nes a week ore times a week			One Unit	One Unit	One Unit	One Unit	One Unit
2. How many st you are drinking? (0) 1 - 2 (1) 3 - 4 (2) 5 - 6 (3) 7 - 9 (4) 10 or r		s do you have on a t	ypical day when	1/2 pint of ordinary strength beer lager or cider	1 small glass of wine	1 single measure of spirits	1 small glass of sherry	1 single measure of aperitifs
(0) Never (1) Less tl (2) Month (3) Weekl		tandard drinks on on	e occasion?					
_	Record total of the decord		nsumption further					
<u> </u>	<u> </u>	Family Member		Family	Member			
	CANCER	,	HIGH BLOOD PRESSURE					
	STROKE		ASTHMA					
	DIABETES		CORONARY HEART DISEASE					
	OTHER							
Are you allergic to  If Yes, to very  h) For Women Or  Have you had a Hy  If Yes, wh	what are you allergic  oly esterectomy en?  Date: .							
Signed:								pa941