**Check List**

**This is for office use only – patient does not need to complete this form. (Please date stamp form)**

|  |  |
| --- | --- |
|  | **Please Tick** |
| **Top sheet signed, and handed back to patient** |  |
| **Practice Leaflet given** |  |
| **Purple Form** |  |
| **Settlement status** |  |
| **Health Questionnaire** |  |
| **Proof of Address** |  |
| **Identification** |  |
| **NHS Number** |  |
| **Next of Kin Details** |  |
| **Controlled Drugs Agreement form signed** |  |
| **Signature** |  |
| **Right-Handed Side for regular medication (to be placed in doctors tray)** |  |
| **My Health Online Account Request** |  |
| **Text Message consent** |  |
| **Previous GP/date entered Country** |  |
| **Patient advised 2-week turnaround** |  |
| **Staff name** |  |

**Date Stamp :**

**Cwmfelin Medical Centre**

298 Carmarthen Road Swansea SA1 1HW

Tel No: 01792 653941

**www.cwmfelin.co.uk**

**GP Out of Hours Service – Phone 111**

**(6.30 pm to 8.00 am, weekends and bank holidays)**

**NEW PATIENT REGISTRATION FORM**

To complete your registration, we will need to see proof of address (Council Tax Bill or Tenancy Agreement) and photographic proof of identity (passport, photo id, driving licence). Only in exceptional circumstances, and at the discretion of the GP’s will proof of address be sufficient to complete the registration of an adult. Patients from abroad will need to provide evidence of settled or pre-settled status.

Please retain this (top) page and complete the rest of the form and return it to Reception with the completed GMS1 Registration Form. Children aged 0-16 years will need a separate form completed on their behalf. It is important that you answer as many questions as possible. For your convenience some questions can be answered by circling the answer or ticking the box.

If you are going to need medication, please telephone for an appointment one morning at 8am before your current medication supplies run out.

Provided you live inside our Practice Area you will be registered with the surgery.

If you or any of your family move house or change any of your telephone numbers (especially mobile numbers) it is important that we are told immediately since we will use these details to contact you when necessary. Change of Contact Details forms are available from the reception desk.

Everybody at the surgery has a right to be treated with dignity and respect. The Doctors take their duty of care towards the staff very seriously and operate a “Zero Tolerance” Policy which they will invoke when necessary. Anyone exhibiting inappropriate behaviour towards any member of staff risks being removed from the practice list.

In some circumstances patients may be asked to sign a behavioural contract before a consultation/treatment commences.

**DNA Policy**

**If you are unable to keep an appointment, then please cancel it.  If you do not attend your appointment, you waste the doctors or nurses time, deny other patients the opportunity to see them and increase the overall waiting time for routine appointments.  If you fail to attend 2 appointments a warning letter will be issued. A further DNA of an appointment may result in you being removed from our patient list and you will need to register with another GP practice.**

Please refer to the Practice Leaflet for more information about the surgery and its services.

**Please sign and date to confirm that you are happy to accept the surgery’s terms and conditions before we can register you. (Top copy to be retained by patient)**

Name……………………………………………….

Signature………………………………………….

Date …………………….

**Controlled Drugs**

Due to the risks of addictions and current guidelines regarding adverse health outcomes we will not be continuing prescriptions of the following if you decide to join our surgery.

**Gabapentinoids –**

**Gabapentin, Neurontin, Pregabalin, Lyrica, Alzain, Axalid**

**Opiates –**

**Morphine, MST, Zomorph, Oxycodone, Longtec, Shortec, Oxycontin, Tramadol, Buprenorphine, Temgesic, Butrans, Reletrans, Hapoctasin, Butec, Transtec, Fentanyl, Durogesic, Matrifen, Tapentadol, Palexia**

**Hypnotics/Anxiolytics/Benzodiazepines –**

**Diazepam, Temazepam, Nitrazepam, Lorazepam, Oxazepam, Chlordiazepoxide, Zopiclone, Zolpidem**

You will need to agree to a reducing regime for your own personal safety. Please complete the sections below:-

**Name…………………………………………**

**NHS Number ……………………………….**

**Signature ……………………………………**

**Cwmfelin Medical Centre**

298 Carmarthen Road Swansea SA1 1HW

Tel No: 01792 653941

**NEW PATIENT REGISTRATION FORM**

**DATE: …………………………….**

**Do you have proof of settled or pre settled residency (Overseas patients existing or new)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes** |  | **No** |  |

**If the answer is No we cannot register you**

**You will need to apply online for settled status. www.swansea.gov.uk>EUsettlement**

**If you need help to apply for the scheme telephone 0333 445 675.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever been registered with this surgery before?** | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If “Yes” - Since you were last registered here have you changed your name?** | **Yes** |  | **No** |  |

**If “Yes” – Previous Name(s) used ...............................................................**

|  |
| --- |
|  |

**PERSONAL DETAILS**

**NAME…………....…………………….....…... TITLE Mr / Mrs / Miss / Other**

**ADDRESS…………………………………………………………………………………………...............……………………………………………………………………………………….……………………….……………………………………………………………………………………Post Code …..……………................**

***(Staff – Lives in Nursing Home Code 13F61, Lives in Residential Home 13FK)***

**DATE OF BIRTH:…………………………**

**Tel Numbers: Home………………..……….**

**Mobile………………………..**

**Do you consent to being contacted via text/email? …………**

**Work….……………………...**

**Email……………………………………………………..**

**Are you: Single / Married / Separated / Divorced / Widowed / Cohabiting**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have any children?** | **Yes** |  | **No** |  |

**If “Yes” please give names, ages and dates of birth**

**………………………………………………………………………………………….………………………..………………………………………………………………...….….………………………………………………………………………………......**

***(Staff – notify Health Visitors for children under 5)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever served with HM Forces?** | **Yes** |  | **No** |  |

**Enlistment Date: ............... Discharge Date: .............. Service No...............**

***(Staff – enter read code Armed Forces Veteran 13Ji and Alert - Veteran)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you speak English?** | **Yes** |  | **No** |  |
|  |  |  |  |  |
| **Will you require an interpreter?** | **Yes** |  | **No** |  |

**If “Yes” what is your first spoken language? .............................................**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you a Carer, registered or otherwise?** | **Yes** |  | **No** |  |

**If “Yes” please ask the Receptionist for the Carers Forms to complete.**

**(S*taff -arrange appropriate Carer consent forms and computer entry)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have any recognised disability?** | **Yes** |  | **No** |  |

**If “Yes” please state the type of disability and your special needs ………………………………………………………………………………………….**

**Do you have a sensory or communication disability? Yes No**

**What communication support do you need?**

**………………………………………………………………………………………...**

**Next of Kin Details**

**Name ………………………………………………………………………………..**

**Address……………………………………………………………………………..**

**Relationship ……………………………………………………………………….**

**Contact Number …………………………………………………………………..**

**Does this person have Financial power of Attorney Yes/No**

**Does this person have Power of Attorney for Health Yes/No**

**It is the patient’s responsibility to make sure the above details are kept up to date.**

**DRUGS & MEDICINES**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Are you currently on any medication?** |  | **YES** |  |  | **NO** |  |

**If “Yes” attach your list of medication**

**ALLERGIES**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Are you allergic to any treatments or medication?** |  | **YES** |  |  | **NO** |  |

**If “yes” please give details ……………………………………………………**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has any medication upset you in any way?** |  | **YES** |  |  | **NO** |  |

**If “yes” please give details ……………………………………………………**

**………………………………………………………………………………………….**

**SMOKING**

**Which of the following describes your smoking habits?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of cigarettes per day** |  | **Never smoked** |  |
| **Number of cigars per day** |  | **Stopped smoking** |  |
| **Amount in gm of tobacco per week** |  | **Date stopped smoking** |  |

**ALCOHOL**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Do you drink alcohol?** |  | **YES** |  |  | **NO** |  |

**If “yes” how many units on average per week……………………**

**(1 pint of beer = 2 units, 1 glass of wine/sherry = 1 unit and 1 measure of spirits = 1 unit)**

**Have any of your close blood relatives (parents, brothers, sisters, children) suffered from any of the following illnesses?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **√ if Yes** | **Family Member Relationship** |  |
| **Heart disease starting over 60** |  |  |  |
| **Heart disease starting under 60** |  |  |  |
| **CVA/Stroke** |  |  |  |
| **Diabetes** |  |  |  |
| **Asthma** |  |  |  |

**Patient Ethnic Origin Questionnaire**

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare as some medical conditions are more common in certain ethnic communities. Choose ONE section from A to E and then tick ONE box

The collection of this data is in accordance with the legislation contained in the Race Relations Act and follows the recommendations of the Commission for Racial Equality (CRE). The categories of race origin listed below follow the recommended categories for public bodies in England and Wales, and are consistent with the presentation and collection of ethnicity detail within the 2001 Census.

|  |  |  |  |
| --- | --- | --- | --- |
| A | White |  |  |
|  |  |  | British |
|  |  |  | Irish |
|  |  |  | Any other white background |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| B | Mixed |  |  |
|  |  |  | White and Black Caribbean |
|  |  |  | White and Black African |
|  |  |  | White and Asian |
|  |  |  | Other Mixed Background please write below |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| C | Asian or Asian British | | |
|  |  |  | Indian |
|  |  |  | Pakistani |
|  |  |  | Bangladeshi |
|  |  |  | Any other Asian background please write below |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| D | Black or Black British | | |
|  |  |  | Caribbean |
|  |  |  | African |
|  |  |  | Any other black background please write below |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| E | Chinese or other ethnic group | | |
|  |  |  | Chinese |
|  |  |  | Any other please write below |
|  |  |  |  |
|  |  |  |  |