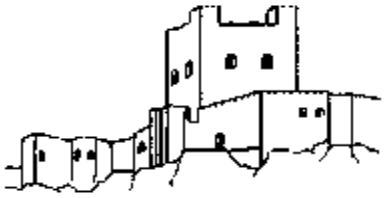

Date of Registration:	
EMIS Number:	Your Initials:
LONG STAY/SHORT STAY	EXPIRY DATE:

The Castle Practice

(May 2019 Version)

TEMPORARY RESIDENT FORM

Please complete all sections of this form in their entirety
The completion of this form is essential for our records.

SECTION A - PERSONAL DETAILS:

PLACE OF BIRTH:

NAME:	**DOB:**
	H&C No:
TEMPORARY ADDRESS	**PERMANENT HOME ADDRESS**
HOME TELEPHONE NO:	**MOBILE NO:**
WORK NO:	**EMAIL ADDRESS:**
OWN GP DETAILS - NAME AND ADDRESS **You MUST complete this section**	Have you registered with the Castle Practice Before? Yes/No Have you ever been registered within the UK? Yes/No First Language:

ETHNIC ORIGIN - Please circle accordingly

White	**Asian or Asian British**	**Mixed**	**Black or Black British**
British	Indian	White and Black Caribbean	Caribbean
Irish	Pakistani	White and Black African	African
Other	Bangladeshi	White and Asian	Other
	Other	Other	

Chinese or other Ethinc group	**Not Stated or Other**
Chinese	
Other	

SECTION B - HEALTH STATUS INFORMATION

SMOKING STATUS - Have you ever smoked?	Yes/No
If Yes, are you a current smoker?	Yes/No
If Yes, how many do you smoke per day?	
If Yes, please see additional handout given by receptionist.	
ALCOHOL STATUS - Do you drink alcohol?	Yes/No
If Yes, how many units would you drink per week?	

TO BE COMPLETED BY RECEPTION - TEMPORARY RESIDENT STATUS

- ☐ SHORT STAY - UP TO 15 DAYS
- ☐ LONG STAY - 16DAYS TO 3 MONTHS
- ☐ TELEPHONE SERVICES ONLY
- CONTRACEPTIVE SERVICES ☐ IUD ☐ NON IUD
- ☐ EMERGENCY TREATMENT
- ☐ IMMEDIATELY NECESSARY TREATMENT
- DATE OF INITIAL TREATMENT _____

The Castle Practice

Date of Registration:	
EMIS Number:	Your Initials:
LONG STAY/SHORT STAY	EXPIRY DATE:

TEMPORARY RESIDENT FORM

SECTION C - MEDICAL HISTORY

Do you suffer from -	Asthma	Yes/No	
	Heart Disease	Yes/No	
	Diabetes	Yes/No	
	Stroke	Yes/No	
	Epilepsy	Yes/No	
	COPD/Bronchitis	Yes/No	
	Thyroid Problems	Yes/No	
	High Blood Pressure	Yes/No	
	Any other significant medical condition?	Yes/No	

If you answered Yes to any of the above, please list your current medication

Medication	Strength	Dose

Castle Practice participates in the Department of Health led Benzodiazepines Reduction and Opiodes Reduction programme.
Patients should be aware that prescriptions and medications will be reviewed in line with the Department of Health Guidelines.

PLEASE TICK HERE TO CONFIRM YOU HAVE READ THIS NOTICE ☐

ALLERGIES - Please list any known allergies you have to medication (ie penicillin)

VACCINATIONS - Please list any know vaccinations received in the last 10 years

_____

_____

WOMEN ONLY - When was your last cervical smear? Date: _____

If you are currently being prescribed contraception, please circle accordingly:

IUD (coil) Pill Depo-Provera Injection Implanon

CHECK LIST - FOR COMPLETION BY RECEPTION

Checked EU/Non EU Country	*Yes*	*Date:*	_____	*(initial)*	_____
Photographic ID copied	*Yes*	*Date:*	_____	*(initial)*	_____
Visa/Permit copied (if necessary)	*Yes*	*Date:*	_____	*(initial)*	_____
GP Alerts Database checked	*Yes*	*Date:*	_____	*(initial)*	_____
Ethnic Origin coded	*Yes*	*Date:*	_____	*(initial)*	_____
Smoking Status/Alcohol Status Coded	*Yes*	*Date:*	_____	*(initial)*	_____
Smoking Information Leaflet Given (if smoker)	*Yes*	*Date:*	_____	*(initial)*	_____