Website: www.birchwoodpractice.co.uk

NEW PATIENT REGISTRATION FORM

About You

Title: ……. Surname: ……………………………………

Forename(s): …………………….…………….…………..

Do you have a preferred name (eg Jennie vs Jennifer)?

……………………………………………………………

Previous Surname: ……………………………….……. Date of Birth: ……………………...

Gender: ……………………..………….………….………. NHS Number: ……………………..

Previous GP Practice Address:

……………………………………..…………….……………..……………….……….……..

……………………………………….……….………….........................…………….…………….…..…

Contact Information

Address:……………………..………….………….…………..…………….……….…………….…..…

……………………………………….…………..…………..……………..…………..…………..………..

Post Code: ………………………………………….………..…

Telephone: ……………..…………….………….………..

Mobile: ………………………….……….…….………..…...

Email: ……………………………………….………….…...

Residency

Do you live in a residential/nursing home? **Yes** ☐ **No** ☐

Do you have a door access key code you would like kept on record?

……..……

Previous address in the UK (if applicable):
……..……..……..……..……

……..……..……..……..……..……..……

If you are from abroad, what date did you come to UK?

……..……..……..……..……..……..……..……..……..

Occupation

What is your occupation?

……..……..……..……..……..……..…

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

I AM a Military Veteran	☐	**I AM** currently serving in the Reserve Forces	☐
I AM married/civil partnership to a serving member of the Regular/Reserve Armed Forces	☐	**I AM** married/civil partnership to a Military Veteran	☐
I AM under 18 and my parent(s) are serving member(s) of the armed forces.	☐	**I AM** under 18 and my parent(s) are veteran(s) of the armed forces.	☐

Date of discharge (if applicable):

……..……..……..……..……...

Students

Are you studying in the UK on a student visa? **Yes** ☐
No ☐

Have you moved address due to starting a higher education course? **Yes** ☐
No ☐

If yes to either of the above questions, please provide your course dates:

Start: ……..……..……...

Finish: ……..……..……..

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs. If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

British or mixed British	☐	Pakistani	☐
Irish	☐	Bangladeshi	☐
African	☐	Chinese	☐
Caribbean	☐	Other (please state):	☐
Indian	☐		

Preferred Title

How would you like us to refer to you (eg Mr, Mrs, Miss, Mx)?
……..……..……..……..……..……..……..……..

Religious Affiliation

Do you have a religious affiliation (please give details if so)?

……..……..……..……..……..……..……..……..

Place of Birth

In which Country and City were you born?

……

Main Language

Which is your main language?

……

Do you speak English?

……

Carer Status

Are you yourself a carer? **Yes** ☐
No ☐.

Do you have a carer? **Yes** ☐
No ☐

If yes, please provide their:

Name: ……..……..…..

Relationship to you: ……..….

Are they a patient here?

Yes ☐

No ☐

Next of Kin (For Emergency Contact)

Surname: ……..……..

Forename(s): ……..……..……..

Gender: ……..……..……..……

Relationship to you: ……...

Telephone: ……..……..……..……..…...

Mobile: ……..……..……..

Can we discuss any aspect of your medical record with your next of kin? **Yes** ☐
No ☐

*If yes – please ask Reception for a "Proxy Access Form"

Marital Status

Please indicate your marital status by ticking the below box:

Single	☐	Civil partnership dissolved	☐
Married	☐	Widowed	☐
Civil partner	☐	Other (please state):	☐
Divorced	☐		

Contacting You

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐
No ☐

Record Sharing

Birchwood Practice would like to hold, process and share your personal and medical records, manually and electronically, as outlined below (For more information visit **https://www.birchwoodpractice.co.uk/confidentiality**

SytmOne Sharing
Locally for the purposes of the Local Shared Electronic Record (CHIE) and the OOH Hub for my direct health care.

Opt In ☐ **Opt Out** ☐

Summary Care Record
Nationally for the purposes of National Shared Electronic Record (SCR) for my direct health care.

Opt In ☐ **Opt Out** ☐

Research
Nationally for the purposes of improving and planning the health and care of current and future generations (indirect health care)

Opt In ☐ **Opt Out** ☐

★ Signed: ……..……..……..……..

Date: ……..……..……..

Print name:
……..……..……..……..……..……..……..…

Please note – We use partner software suppliers/businesses who may have access to specific parts of your data (e.g. to send letters/text reminders). We have gained approval from Dorset CCG to use these companies and we are confident your data is secure. If you would like to view who our software suppliers/businesses are and what information they can see please visit https://www.birchwoodpractice.co.uk/privacy-policy

We do not share your data for the purposes of education, research, audit or administration without your express consent (i.e. we would ask you every time for permission before doing this). The only exception to this would be where the data was anonymised, i.e. not identifiable back to you.

Electronic Prescribing Service (EPS)

Please nominate a pharmacy below for all your regular prescriptions to be sent for collection.

Nominated pharmacy:

……..……..……..……..……..……..……

Postcode: ……..

If you know you need a separate appliance pharmacy please nominate below:

Nominated appliance pharmacy:

……..……..……..……..……..…..

Postcode: ……..

Donation Wishes

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.
If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit: https://www.organdonation.nhs.uk/register-your-decision/do-not-donate/

Do you have a donor card or are you on the organ donation register? **Yes** ☐ **No** ☐

Have you opted out? **Yes** ☐ **No** ☐

Do you donate blood? **Yes** ☐ **No** ☐

Resuscitation Wishes and Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes** ☐ **No** ☐

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes** ☐ **No** ☐

★ *If yes to either of the above questions, please supply details of who holds this and where (and supply a copy with this form for your medical notes).*

Details……
……

Smoking Status

Do you smoke? **Yes** ☐ **No** ☐

If yes, how many cigarettes do you smoke daily:
……

If no, have you smoked in the past? **Yes** ☐ **No** ☐

Do you use electronic cigarettes/vape? **Yes** ☐ **No** ☐

Smoking is the UK's single greatest cause of preventable illness.
Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.
If you would like help and advice on how to give up smoking, please contact www.livewelldorset.co.uk/stop-smoking *or ask at reception.*

Blood Pressure

If you have a home blood pressure monitor please provide an up-to-date reading below:

B/P: ……..……..……..

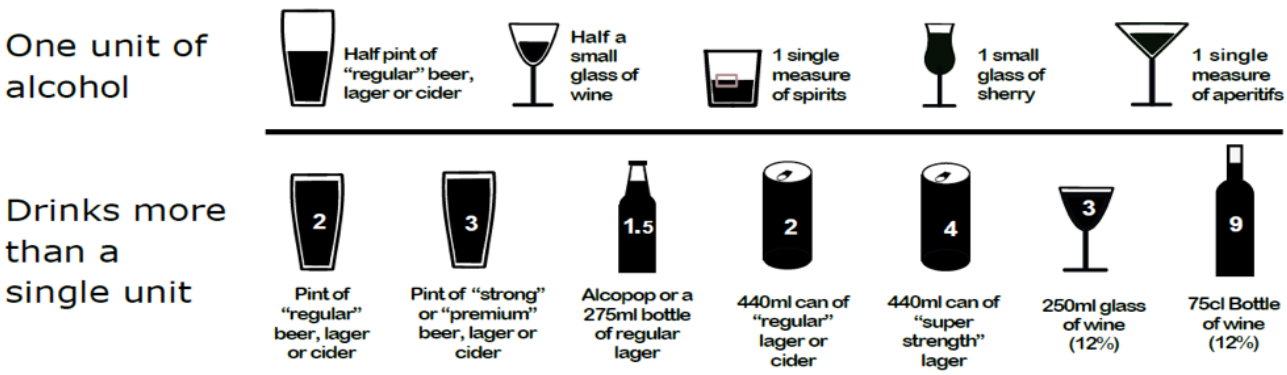
Pulse: ……..…..

Date taken: ……..….

Alcohol Intake

Do you ever drink alcohol? **Yes** ☐ **No** ☐

If yes, how many units a week do you drink on an average week? ……..



Exercise

Please indicate your exercise status by ticking one box below:

Exercise physically impossible	☐	Enjoys moderate exercise	☐

Avoids even trivial exercise	☐	Enjoys heavy exercise	☐
Enjoys light exercise	☐	Competitive athlete	☐

Weight/Height

What is your weight?

……

What is your height?

……

If you would like advice on managing a healthy weight, please contact https://www.nhs.uk/live-well/ or reception who will be able to direct you to the most appropriate service.

General Practice Physical Activity Questionnaire

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.)	☐
b	I spend most of my time at work sitting (such as in an office)	☐
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	☐
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	☐
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	☐

2. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more

a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.	☐	☐	☐	☐
b	Cycling, including cycling to work and during leisure time	☐	☐	☐	☐
c	Walking, including walking to work, shopping, for pleasure etc.	☐	☐	☐	☐
d	Housework/Childcare	☐	☐	☐	☐
e	Gardening/DIY	☐	☐	☐	☐

3. How would you describe your usual walking pace?

		Please mark one box only
a	Slow pace (i.e. less than 3 mph)	☐
b	Steady average pace	☐
c	Brisk pace	☐
d	Fast pace (i.e. over 4mph)	☐

AUDIT-C

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Score: ……..

If your score is less than 5 please proceed to the 'Disabilities / Accessible Information Standards' section.

A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.

Questions	Scoring system					Your score
	0	1	2	3	4	
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	

Total Score (including the score above): ……

If you would like help and advice on how to reduce your alcohol intake, please contact https://www.drinkaware.co.uk/ or ask at reception.

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs? **Yes** ☐
No ☐

If yes, please state your needs:
……

……

Are you blind/partially sighted? **Blind** ☐ **Partially sighted** ☐

Do you have significant problems with your hearing?

Deafness ☐ **Hearing difficulty** ☐

Do you have significant mobility issues? **Yes** ☐ **No** ☐

If yes, are you housebound? **Yes** ☐ **No** ☐
(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)

Family History and Past Medical History

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Who (e.g. Father)?

Heart disease (heart attack/angina) **Yes** ☐ **No** ☐

If yes, what age were they at onset? **< 60 yrs.** ☐ **≥ 60 yrs.** ☐

Asthma **Yes** ☐ **No** ☐

Hypertension	**Yes** ☐	**No** ☐
Diabetes mellitus	**Yes** ☐	**No** ☐
Stroke	**Yes** ☐	**No** ☐
Rheumatoid arthritis	**Yes** ☐	**No** ☐
Cancer	**Yes** ☐	**No** ☐
Epilepsy	**Yes** ☐	**No** ☐

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing?

Medications

Please provide a list of repeat medications you take:

……..……..……..…

……..……..……..……..……..……..……..…

Allergies

Please list any drug or food allergies that you have:

……..……..……..……..……..……..……..……

For Female Patients Only

Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes, when was this last done and what was the result?

……..……..……..

………

Have you had a hysterectomy? **Yes** ☐
No ☐

Do you still have your ovaries? **Yes** ☐
No ☐

Are you currently pregnant? **Yes** ☐
No ☐

If yes, please ensure you are under the care of a midwife. If you're not currently under the care of a midwife please speak to reception regarding this.

Which method of contraception (if any) are you using at present?

…………………………………………………..

If you have an implant/coil, when was this fitted?

…………………………………………………………………….

Consent

I consent that the information given is true to the best of my knowledge.

★ Signed: …………………………………………………………. Date: ………………

Print name: …………………………………………………………….

ONLINE SERVICES

Patients are able to register for online services to manage their appointments, repeat prescriptions and medical records.

There are a number of applications which can be used to register. If you are over 13, and have a smart phone or tablet, the preferred way is to use the **NHS App**.

APPLE USERS:

Scan this QR code:
OR
Go to the App store and search for the NHS App

ANDROID USERS:

Scan this QR code:
OR
Go to the Play store and search for the NHS App

You will then be able to self-register on the app by uploading a photo of your ID, and recording a short video.