Springfields Medical Centre

Bath Street Health and Wellbeing Centre Legh Street Warrington WA1 1UG

Tel: 01925 843880, Web: www.springfieldsmedicalcentre.co.uk

**\*\*ADULT REGISTRATION FORM\*\***

Thank you for applying to join Springfields Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You will need to supply TWO forms of identification with the completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and proof of address (such as a recent BANK STATEMENT or UTILITY BILL)**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

***\*\*YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (\*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION\*\****

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| **\***Title: | \*Surname: |  | **\***First names: |
| **\***Any previous surname(s) (if applicable): |  | **\***Date of Birth: DD / MM / YYYY |
| **\***[ ]  Male [ ]  Female [ ]  Intermediate [ ]  Unspecified |  | NHS No. [ ] [ ] [ ]  [ ] [ ] [ ]  [ ] [ ] [ ] [ ]  |
| \*Town and country of birth:  |  | **\***Home address: |
| **\***Home telephone No.: |
| Work telephone No.:  |  | \*Postcode: |
| **\***Mobile No. (if you have one):  |  | Email address: |
| **Please help us trace your previous medical records by providing the following information** |
| \*Previous address in the UK (if applicable):Postcode: |  | \*Name of previous doctor: |
| \*Address of previous doctor: |

**If you are from abroad**

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| \*Your first UK address where you registered with a GP if you were previously living abroad:Postcode: |  | \*If previously a resident in the UK, date of leaving: |
| \*Date you first came to live in the UK (if applicable): |

 **If you are returning from the Armed Forces**

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| Address before enlisting:Postcode: |  | Service or Personnel No: |
| Enlistment date:Date left Armed Forces:- |

**Additional Details about you**

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| What is your ethnic group? **Main spoken language (E.g. English):****White** [ ]  British [ ]  Irish [ ]  Other White (please specify):**Black** [ ]  Caribbean [ ]  African [ ]  Other Black (please specify):**Asian** [ ]  Indian [ ]  Pakistani [ ]  Chinese [ ]  Other Asian (please specify):**Mixed** [ ]  White + Black Caribbean [ ]  White + African [ ]  White + Asian [ ]  Other mixed: |

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| (**for women only)** Have you had a cervical smear?Yes/No – Please state where, when and the result if possible |

**Next Of Kin / Emergency contact**

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| 1 | Name / Relationship to you / Telephone No. / Address (if different to yours) |

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| 2 | Name / Relationship to you / Telephone No. / Address (if different to yours) |

**Carers Information**

*A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.*

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| **Are you looked after by someone who couldn’t manage without you?** [ ]  Yes [ ]  NoIf yes, what is their name and contact number?Do you consent for your carer to be informed about your medical care? [ ]  Yes [ ]  No |

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| **Do you look after or support someone who couldn’t manage without you?** [ ]  Yes [ ]  NoIf yes, do they look after someone who is a patient of Springfields Medical Centre? [ ]  Yes [ ]  No [ ]  Don’t knowIf yes, what is their name: Are they a [ ]  Friend [ ]  Relative [ ]  Neighbour  |

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| **\***Do you take any regular medication? [ ]  Yes [ ]  No (if yes please specify)Please state name and dose (including contraceptive pill) |

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| **\***Are you allergic to any medicines? [ ]  Yes [ ]  No (if yes please specify) |

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| **\***List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of) : |

**Have you ever had any of the following conditions?**

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| **Epilepsy** | [ ]  Yes  | Year |  | **Rheumatoid Arthritis** | [ ]  Yes  | Year |
| **High Blood Pressure** | [ ]  Yes  | Year |  | **Mental Illness (inc Depression)** | [ ]  Yes  | Year |
| **Heart Attack** | [ ]  Yes  | Year |  | **Diabetes (type 1 or type 2)** | [ ]  Yes  | Year |
| **Angina (stable / unstable)** | [ ]  Yes  | Year |  | **Asthma** | [ ]  Yes  | Year |
| **Stroke** | [ ]  Yes  | Year |  | **COPD (or Emphysema)** | [ ]  Yes  | Year |
| **Transient Ischaemic Attack** | [ ]  Yes  | Year |  | **Osteoporosis / Bone Fractures** | [ ]  Yes  | Year |
| **Cancer** | [ ]  Yes  | Year |  | **Peripheral Vascular Disease** | [ ]  Yes  | Year |

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| List any serious illnesses / operations / accidents / disabilities and the year they took place: |

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| Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs: |

**Do you have Family History of any of the following?**

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| **High Blood Pressure** | [ ]  Yes  | Who |  | **DVT / Pulmonary Embolism** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged >60 yrs | [ ]  Yes  | Who |  | **Breast Cancer** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged <60 yrs | [ ]  Yes  | Who |  | **Any Cancer**Specify type: | [ ]  Yes  | Who |
| **Raised Cholesterol** | [ ]  Yes  | Who |  | **Thyroid disorder** | [ ]  Yes  | Who |
| **Stroke / CVA** | [ ]  Yes  | Who |  | **Epilepsy** | [ ]  Yes  | Who |
| **Asthma** | [ ]  Yes  | Who |  | **Osteoporosis** | [ ]  Yes  | Who |
| **Diabetes** | [ ]  Yes  | Who |  | **Other (please specify)** | Who |

**Please tell us about your smoking habits**

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| **\***Do you smoke? [ ]  Yes [ ]  NoIf Yes, what do they primarily smoke:Cigarettes / Cigar / Pipe / Vape **(please circle)**How many do you smoke a day? |  | Are you an ex-smoker [ ]  Yes [ ]  NoWhen did you quit?How many did they used to smoke a day? |
| Would you like advice on quitting? [ ]  Yes [ ]  No |  |  |

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| Do you exercise regularly? [ ]  Yes [ ]  No If yes, what exercise do you take and how often: |

**Please tell us about your alcohol consumption**

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| **1 unit =** normal half pint beer (284 ml) 4% **or** Single shot spirit (25ml) 40%. **1.5 units =** small glass of wine (125 ml) 12.5% or Alcopop (275 ml) 5.5%**2 units =** strong half pint beer (284 ml) 6.5% **or** medium glass of wine (175ml) 12.5% **or** normal large bottle/can beer (440ml) 4.5%**3 units =** strong bottle/can beer (440ml) 6.5% **or** bottle of wine (750ml) 12.5% **or** bottle spirits (750ml) 40% **or** large glass of wine (250ml) 12.5% |
| **QUESTIONS** (Please circle your answers in the boxes below) | **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol | **Never** | **Monthly or less** | **2 – 4 times per month** | **2 – 4 times per week** | **4+times per week** |
| How many units of alcohol do you drink on a typical day when you are drinking? | **1 -2** | **3- 4** | **5-6** | **7-9** | **10+** |
| How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| **IF YOU SCORE A TOTAL OF 5 OR MORE ON THE ABOVE QUESTIONS, PLEASE COMPLETE THE FURTHER 7 QUESTIONS BELOW** |
| How often in 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 in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you had a feeling of guilt or regret after drinking? |  | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often in the last year have you not been able to remember what happened when drinking the night before? |  | Less than monthly | Monthly | Weekly | Daily or almost daily |
| Have you or someone 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 |
| **Your total score for all ten questions indicates the following:-****0-7 = sensible drinking 8 – 15 = hazardous drinking** **16 – 19 = harmful drinking 20+ = possible dependence** **Would you like information or advice about alcohol consumption Y/N** |

**Communication Preferences**

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| We may want to contact you by email, send appointment reminders to your mobile and leave messages on your answering machine, if you have one. **Tick these boxes if you DO NOT wish to be contacted in this way:** [ ]  **Email** [ ]  **SMS** [ ]  **Answering machine** [ ]  **Letter Post** |

**Data Sharing**

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| **Summary Care Record**We would like to recommend that you take advantage of the Summary Care Record (SCR). The Core SCR includes important information about your health: Medicines you are taking, allergies you suffer from and any bad reactions to medicines.You can also choose to have additional information included in your SCR, which can improve the care you receive. This information includes: Your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated – such as where you would prefer to receive care; what support you might need and who should be contacted for more information about youYou may need to be treated by health and care professionals outside of the practice who do not know your medical history. Having the additional information SCR can help the staff involved in your care access information more quickly, allowing them to make informed decisions about your healthcare. More information can be found by visiting [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk)Tick this box if you wish to opt-in to the **Core SCR** [ ] Tick this box if you wish to opt-in to the **Core and Additional SCR** [ ] Tick this box if you wish to opt-out from the **SCR** [ ]  |

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| **Medical Interoperability Gateway (MIG)**Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much broader view of their records but only with local NHS providers – and only when you give explicit consent at the point of care.For more information please visit <https://healthcaregateway.co.uk/> |

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| **The Accessible Information Standard (AIS)**Please use this space to tell us about any specific communication needs you have. i.e. needing information in large print or deafblind telephone contact. For further information please visit [**https://www.england.nhs.uk/ourwork/accessibleinfo/**](https://www.england.nhs.uk/ourwork/accessibleinfo/) |

**Donor Registration Choices**

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| **NHS Organ Donor Registration**“I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after their death”. Please tick the boxes that apply.[ ]  Any of my organs and tissue or…[ ]  Kidneys [ ]  Heart [ ]  Liver [ ]  Corneas [ ]  Lungs [ ]  Pancreas**For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23** |

**Online Patient Access**

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| Once your application to join our practice has been accepted you’ll be able to order your repeat medications, book appointments and . This service is known as **Systmonline**. To register visit **www.springfieldsmedicalcentre.co.uk** or ask reception for an **application form**. You need to bring the completed form to reception then you’ll be given a username and password so you can create the online account.  |

Electronic Prescription Service (EPS)

Yyou will be able to nominate a pharmacy to collect your prescriptions from. EPS enables prescribers, such as GP’s and practice nurses, to send prescriptions electronically to a pharmacy of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service please talk to your pharmacist of choice.

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| **Please record any additional information about you that you think is important for us to know on a separate sheet of paper and attached to this registration form.** |

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| **\*Signed**  |  | **\*Date** DD / MM / YYYY |

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| **SUPPLEMENTARY QUESTIONS** |
| **PATIENT DECLARATION for all patients who are not ordinarily resident in the UK** |
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| Anybody in England can register with a GP practice and receive free medical care from that practice.However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.****The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.****Please tick one of the following boxes:**a) [ ]  I understand that I may need to pay for NHS treatment outside of the GP practice b) [ ]  I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the Surcharge”), when accompanied by a valid visa. I can provide documents to support this when requestedc) [ ]  I do not know my chargeable statusI declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.**A parent/guardian should complete the form on behalf of a child under 16.** |

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| **\*Signed:** |  | **\*Date:** | **DD / MM / YYYY** |
| **\*Print name:** |  | **\*Relationship**  **to patient:** |  |
| **\*On behalf of:** |  |

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| **Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.** |
| **NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC)DETAILS and S1 FORMS** |
| **Do you have a non-UK EHIC or PRC?** | [ ]  Yes [ ]  No | **If yes, please enter details from your EHIC or PRC below:** |
| *If you are visiting from another EEA* *Country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.* | **Country Code:**   |  |
| **3: Name** |  |
| **4: Given Names** |  |
| **5: Date of Birth** | **DD / MM / YYYY** |
| **6: Personal Identification****Number** |  |
| **7: Identification number****of the institution** |  |
| **8: Identification number of the card** |  |
| **9: Expiry Date** | **DD / MM / YYYY** |
| **PRC validity period (a) From:** | **DD / MM / YYYY** | **(b) To:** | **DD / MM / YYYY** |
| Please tick [ ]  if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.** |
| **How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. |

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| **FOR OFFICE USE ONLY** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Initials:\_\_\_\_\_\_\_\_\_\_ |
| **BIRTH CERT. SEEN [ ]  *Or* ADDRESS ID SEEN [ ]  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Or RED BOOK SEEN [ ]**  |