

The Paradise Road Practice

BRING PHOTO ID & PROOF OF ADDRESS when you register.

It can sometimes take a while for your previous doctor's records to reach us. It would help us to have some basic details. Please complete this question and hand it in at reception. **PLEASE USE BLOCK LETTERS.**

Date: **Your named GP is, Dr Cindy Lee**

First name:

Surname:

Mr/Miss/ Mrs/Ms : **Date of Birth:**

Address: **Post Code:**

..... **Telephone: Home** **Mobile:**

Email: **Work Telephone:**

What is your preferred telephone number for us to contact you on or leave voicemails?
..... **Occupation:**

NEXT OF KIN (address & telephone number if different from yours)

Name:

Address: **Post Code:**

..... **Relationship:** **Telephone:**

PLEASE REMEMBER TO KEEP ALL THESE CONTACT DETAILS UP TO DATE, BY INFORMATING US OF ANY CHANGES

YOURSELF

Are you a carer? Yes/No

Please list any illnesses, disabilities and operations.

Year	Condition
.....
.....
.....

Please list all medicines, tablets, injections, creams etc you are taking/using

Name	Dose	How often
.....
.....
.....

Are you allergic to anything, e.g medicines, especially antibiotics?
.....

FAMILY HISTORY

Have you or either of your parents, brother or sister suffered from a heart attack, angina or a stroke before the age of 55? Yes/No. If yes, who and which illness?
.....
.....

Have either parents, brother or sister suffered from (please circle) High Blood Pressure, Epilepsy or Fits, Kidney diseases, Diabetes, Cancer, Asthma, Glaucoma, Nervous Disorder or any hereditary complaints?

FOR WOMEN

Date of last Cervial Smear test:

Result:

By whom, GP/Clinic/Hospital?

ADULTS IMMUNISATION

DATE

Tetanus

Polio Booster

Typhoid

Yellow Fever

Other

Are you a smoker? Yes/No If yes, how many a day? Do you smoke cigarettes/ roll ups/ cigars or pipe? If no, have you ever smoked? Yes/No If yes, how many a day and when did you stop?
.....

Do you drink alcohol? Yes/No If yes, approximately how many units of alcohol do you drink in a week?

1 unit of alcohol = half a pint of beer or 1 small glass of wine or 1 pub spirit measure

Exercise: Mild/ Moderate/ Vigorous

Please state your height weight and BMI(if unknown)

SOCIAL BACKGROUND

Are you Single/ Married/ Cohabiting/ Separated/ Divorced/ Widowed?

Accommodation: Flat/House/Other

Interests?

Thank you for completing the questionnaire. New patients over the age of 5 should have a simple health check with one of our nurses. Please arrange an appointment now at reception. If you are interested to use online services for ordering prescription, making appointments please ask for a form at reception.

Score from AUDIT- C (other side)

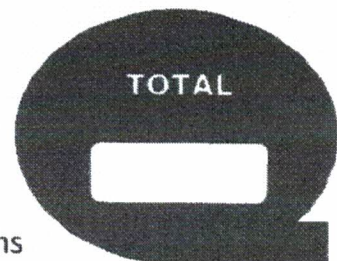


Remaining AUDIT questions

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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions



This is one unit of alcohol...



Half pint of regular beer, lager or cider



1 small glass of wine



1 single measure of spirits



1 small glass of sherry



1 single measure of aperitifs

...and each of these is more than one unit



Pint of Regular Beer/Lager/Cider



Pint of Premium Beer/Lager/Cider



Alcopop or can/bottle of Regular Lager



Can of Premium Lager or Strong Beer



Can of Super Strength Lager



Glass of Wine (175ml)



Bottle of Wine

AUDIT - C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 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 if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.





Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. Also, if you specifically choose to do so, your Summary Care Record can hold other information you have agreed with your GP Practice to have included.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had**
- **YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Records**
- **NO I do not want a Summary Care Record**

If you know that a Summary Care Record was created for you by your previous GP Practice, we would still be grateful if you could complete this form to confirm your current choice.

For more information talk to our Patient Advice and Liaison Service (PALS) (0300 303 5678), GP practice staff or visit the website www.nhscarerecords.nhs.uk

Additional copies of the opt out form can be collected from the GP practice or printed from the website www.nhscarerecords.nhs.uk.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

Children under 16 will automatically have a Summary Care Record containing details of medications, allergies and bad reactions created for them unless their parent or guardian chooses either to notify us that they would like their child to have an enriched Summary Care Record (with other information agreed with the GP Practice to be included) or to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Please return this form to the practice as soon as possible

Yours sincerely

Practice Manager



Your emergency care summary

My Summary Care Record Choice

A. Please complete in BLOCK CAPITALS

Title..... Surname / Family name.....

Forename(s).....

Address.....

Postcode Phone No..... Date of birth.....

NHS Number (if known).....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name..... Your signature.....

Relationship to patient Date

Summary Care Record Options	Please Tick
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had	
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Records <i>Please indicate what information you would like adding if you know</i>	
NO I do not want a Summary Care Record	

If you do not return this form, a Summary Care Record will be created for you based on implied consent.

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now, with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

CONSENT FORM

DATE:

If you require one or all of the following services we will need to obtain your consent.

REPEAT PRESCRIPTION

Requesting : Names

Relationship to you

1.

2.

Collecting : Names

Relationship to you

1.

2.

OTHER PAPERWORK

Requesting : Names

Relationship to you

1.

2.

Collecting : Names

Relationship to you

1.

2.

BOOKING APPOINTMENTS

Names

Relationship to you

1.

2.

NAME: **DATE OF BIRTH:**

SIGNATURE :

PLEASE NOTE THAT WE WILL NOT BE ABLE TO ACCEPT APPOINTMENT CANCELLATION BY THIRD PARTY

OPT OUT ? YOU CAN CANCEL THIS FACILITY AT ANY TIME.