THE WILSON PRACTICE

New Patient Registration Form

Please complete and return this confidential questionnaire.

Patients who are age 45 and over: we request that you take your blood pressure using the machine in the far waiting area. Please return the slip with your blood pressure reading to one of our reception team.

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.
If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Contact Details					
Title: Mr / Mrs / Miss / Ms / Mx / Other…					
Full Name:				**Previous Surname if different:**	
Address and Postcode				**Telephone Number:**	
				Work Number	
				Mobile Number:	
				E-mail Address:	
Date of Birth:	**Gender:**			**Marital Status:**	
Occupation:				**Town & Country of Birth**	
Other residents of your home:				**If applicable, date you first came to live in Britain:**	
Housing (Select one)	House	Maisonette	Flat	Mobile Home	Other
Previous Address:					
Previous Doctor Name & Address:					

If returning from Armed Forces:	Your Service or Personnel Number:	Your Enlistment Date:	Date Left The Armed Forces:

Your Weight:	Stones / Ibs.	kg	**Your Height:**	Feet / Inches	cm

Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No Religion	Other religion (state)	

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1	White (Other) 9i2
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your Main or 1st language Spoken / Understood:	

Do you require the help of a Translator / Interpreter?	

Smoking, Alcohol Consumption and Exercise:						
Are you currently a smoker?	Yes	No	**Have you ever been a smoker?**		Yes	No
If Yes, what type of smoker are you?		Cigarettes	Tobacco	Vaping	Other	
How many do you smoke in a week?		Individual:			Packs:	
If you are a smoker and want to stop, please ask for information about local smoking cessation services.						

How often do you exercise?	**No. times per week**		**Type(s) of exercise:**	

Alcohol Consumption

Please complete attached Audit C Questionnaire

Your Medical Background:		
What illnesses have you had & When?		
What operations have you had and When?		
Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	**Yes**	**No –** please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your Parents, Brothers or Sisters or other family members?	Diabetes	Heart attack under age of 60	Cancer (Please Specify Type)	
	Asthma	Stroke	High Blood Pressure	Thyroid Disorder
	Heart Attacks/Disease		Any other important Family Illness?	

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

When was your last smear done?	Date:	What was the result of the smear?	
Was this at your GP's Surgery?	Yes / No (Please state where)	Date of last mammogram (if applicable):	Date:
Method of contraception (if used):			
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?		Yes	No

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	

Next of Kin Details **Please provide us with a name and phone number of your next of Kin and their relationship to you.**	**Name:** **Contact Information:**	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Name:** **Address:** **Telephone:**	
	Signed:	**Date:**
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	*If "Yes", can you please bring a written copy of it to your New Patient Consultation*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	If "Yes", please state their name / address / phone number:

NHS App

The NHS App lets you order repeat prescriptions and book appointment and allows you to access a range of other healthcare services. The App is for people aged 13 and over who are registered with a connected GP surgery and is free to download from the App Store and Google Play.
If you do not have a smartphone or tablet, please speak to a member of the reception team and ask for our Online Access Form.

Data Extraction

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations for emergency care or research and future planning. Please read the accompanying leaflets which detail what part of your record is extracted and how it is used to help other NHS organisations.
For more detailed information and how you can set your preferences please visit our website.

Using Your Data To Contact You – Consent Preferences for Text and Email

In line with the General Data Protection Regulations [2018] we must seek consent to send you information via text and email.
We use text messaging for appointment confirmation and we use both text and email to inform you of results, invite you to health clinics such as asthma, hypertension and medication reviews or to let you know if there are forms or prescriptions waiting for you to collect.
We might also send you invites to health campaigns, such as Flu campaigns if you are eligible to have it free from the NHS, and to gather information about your smoking status and other health information gathering.

These messages are sent via a secure NHS service. We will never send urgent communications via these methods or sensitive clinical data without your permission.

Where you have provided your contact information please let us know if you are happy for us to contact you:

Via Text ☐ **Yes** I would like to **OPT-IN** for text messages

☐ **No**, I would like to **OPT-OUT** for text messages and I am aware this includes text reminders for appointments.

Via Email ☐ **Yes**, I would like to **OPT-IN** for emails

☐ **No,** I would like to **OPT-OUT** for emails

Please ensure that, where you have provided us with your contact details and have opted in for messaging that you keep us informed of your up to date contact details to avoid any breach of your data.

Please also be aware that when we send sensitive information to you electronically it is your responsibility to ensure that this information is kept securely and cannot be accessed by anyone other than yourself unless at your expressed wish.

The Newsletter

We have a practice newsletter that is sent out periodically through the year that updates you on practice affairs and health campaigns. We will send this to anyone that has an email attached to their record. Please let us know if you would like to opt out of this.

I would like to **OPT-OUT** of the practice newsletter ☐

THE WILSON PRACTICE Patient Participation Group (WP-PPG)

The Practice is committed to improving the services it provides for patients.
To do this, it is vital that we hear about patients' experiences and their views for making services better. You can of course tell us directly but from time to time the PPG conducts surveys into specific issues.

Everyone registered with the practice is automatically a member of the WP-PPG.

The Group has an active Committee that runs several health promotion events during the year and supports the practice in a number of ways.

From time to time, the committee seeks new members and additional 'friends' to help with this work.
If you are interested in getting involved, please see the WP-PPG pages on the practice website (www.wilsonpractice.co.uk) or drop a note into reception

NEW PATIENT HEALTH CHECK

If you would like to book a new patient health check please speak with one of the receptionists. The health check will include having your height, weight and blood pressure taken, and a specimen of urine tested (it would be helpful to bring the specimen with you to the appointment).

The Consultation will also establish relevant past medical and family history, including:

- Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health
- Social factors - employment, housing, family circumstances
- Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.

Patient Signature:		**Date:**	

Signature on behalf of Patient:		**Date:**	

Thank you for completing this and the Alcohol consumption form overleaf.
Please return it to Reception to complete your registration

For more information about the services we offer please see our website:
www.wilsonpractice.co.uk

AUDIT-C Alcohol Consumption Questionnaire

This is one unit of alcohol…

…and each of these is more than one unit

AUDIT – C

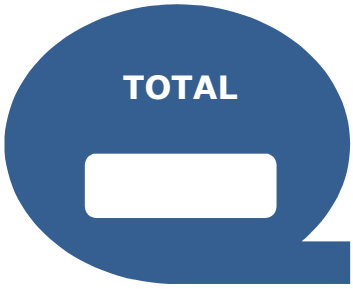
Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often 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.

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 (prev.page)

+

Score of remaining AUDIT questions (this page)

The Wilson Practice
CARERS IDENTIFICATION

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?

If so - You are a carer and we would like to support you.
Please complete this form and hand it in to reception.

If you are agreeable, we will pass your details to the Carers Service, which is a countywide organisation providing relevant information and advice, local support services, newsletters and telephone link line for carers.

YOUR DETAILS:

Name	
Date Of Birth	
Address	
Post Code	
Telephone Number	
Any relevant information	

DETAILS OF THE PERSON YOU LOOK AFTER:

Name	
Date Of Birth	
Address (If Different From Above)	
Post Code	
Telephone Number (If Different From Above)	
GP Details (If Different From Your Own)	

☐ Please pass my details to the Carers Service

The Princess Royal Trust for Carers in Hampshire
Andover Carer Centre
Andover War Memorial Hospital
Andover
SP10 3LB
Tel 01264 835246 or 835205 (Andover)
Email andover@carercentre.com or info@carercentre.com
Company No 2955846 Charity No 1040518
Full name: The Princess Royal Trust for Carers in Hampshire.