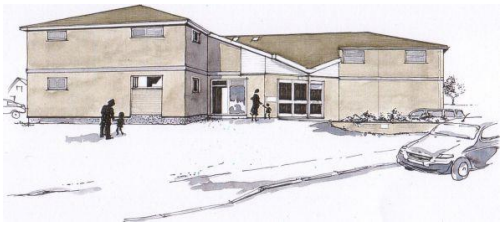
Please note these forms must be completed and passed back to reception **by hand**. They need to be checked by a receptionist before we can register you as a patient. We **cannot register** you without all the relevant information.

Cord Bredemeyer
Ruth Arkle
Kathy Rainsbury
Alan Holman



Roborough Surgery
1 Eastcote Close
Roborough
Plymouth PL6 6PH
Tel: (01752) 701659

Web: www.roboroughsurgery.org.uk

Welcome to Roborough Surgery
New Patient Registration Form

Today's Date:

Do you need this information in another format? Please ask at reception if you require another format.

Please complete this questionnaire (one for each member of the family to be registered with the Practice).

All information will be treated CONFIDENTIALLY

Two forms of i.d. are required to complete the registration **Photo i.d** **Proof of address**		**i.d checked** ☐ ☐	**Type of i.d provided**
Full Name:		**Telephone Number:**	
Mr / Mrs / Miss / Ms / Other……..		**Work Number**	
Address and Postcode: **E-mail Address:** This is required if you wish to access our online services. **GP Online Services makes it easy to book appointments online, request repeat prescriptions and view some of your medical records.** You will need to complete the online communication services form at the back of this questionnaire and provide photo i.d./proof of address **If you are completing this form on behalf of a child who has parental responsibility?** **Give details below:-**		**Mobile Number:** **May we contact you by text message** **YES (#9NdP)** **NO (#9NdQ)** **May we contact you by e-mail** **YES (#9NdS)** **NO (#9Ndy)**	
Date of Birth:	**Previous / Mother's surname if different:**	**Town & Country of Birth**	

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Have you been allocated a named GP you will be registered with?	**YES / NO (XacW2)**
Have you been informed of which GP you will be registered with?	**YES / NO Xab9D)**
Are you a Military Veteran?	**YES / NO** **If Yes please read code (XaX3N)**
Are you an Armed Forces Reservist?	**YES / NO** **If Yes please read code (Xabnw)**
Are you housebound? ***This means you are unable to leave the house for any reason and you require visits by District nurses/doctors***	**YES / NO** **If Yes please read code (#13CA)**

What is your ethnic group? Choose ONE section from A to E then tick the appropriate box on the right to indicate your ethnic group.

Ethnic group	**Tick here**
A: White • British	
• Irish	
• Any other white background (please write in line below)	
B: Mixed • White and Black Caribbean	
• White and Black African	
• White and Asian	
• Any other mixed background (please write in line below)	
C: Asian or Asian British • Indian	
• Pakistani	
• Bangladeshi	
• Any other Asian background (please write in line below)	
D: Black or Black British • Caribbean • African • Any other Black background (please write in line below)	
E: Chinese or other ethnic group • Chinese	
• Any other (please write in line below)	
Not stated/declined • Declined: patient chooses not to supply this information	

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Your main or 1st language Spoken / Understood: (select one)	**English**		**Other please state**	

Your Religion:	**No religion**	**Christian**	**Church of England / Catholic / Other**	**Buddhist**	**Hindu**	**Sikh**
	Muslim	**Jewish**	**Jehovah's Witness**	**Other**	**Not stated / declined**	

Marital Status:		**Gender:**	**Male:**	**Female:**	

What is the name of your partner / spouse?					
Full Names of your Children under 18 and year of their birth: **Other residents of your home (e.g. parent etc):**					
Housing (Select one)	**House**	**Maisonette**	**Flat**	**Mobile Home**	**NHS Number (If Known)**

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

What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present? Please state details	

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Please nominate a Pharmacy for your prescriptions to be sent to electronically	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency + herbal)	

Do you have any ALLERGIES?	**No**	**Yes (please state what you are allergic to and what the reaction was)**

Is your child up to date with the immunisation schedule?	**Please provide details below**

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Do you suffer from any of the following?

	Yes or No	**Date first noted**	**Read Code**
High blood pressure	Y/N		
Diabetes	Y/N		
Heart disease Atrial fibrillation	Y/N		
Stroke	Y/N		
Epilepsy	Y/N		
Stress	Y/N		
Depression	Y/N		
Memory problems	Y/N		
Dementia	Y/N		
Alzheimer's	Y/N		
Asthma Chronic bronchitis Chest problems	Y/N		
Thyroid problems	Y/N		
Cancer	Y/N		
Arthritis	Y/N		
Learning difficulties	Y/N		13Z4E
Sensory disability	Y/N		XaLRW
Physical disability	Y/N		Ub0in
Other disability	Y/N		
Other important conditions	Y/N	**Please list**	

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Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):		
Do you require the help of a Translator / Interpreter?	**For Office use : If Yes please enter codes in Patient records.**	
Do you or your child receive additional support from any professional agency?		
If you are a Carer/Young Carer? If yes please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**	
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.	**Carer Contact Details:**	
	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:**

Women only:

When was your last smear done?	**Date and result**	**ARE YOU PREGNANT?**	**YES** how many weeks?	**NO**

Method of Contraception (if used)	Contraceptive Pill (name)		
Coil – when inserted?	Implant – when inserted?	Sterilised – when?	Other

Would you like an appointment at the practice for contraceptive services (including the pill, coil or implant)?	**Yes**	**NO**

Over 18's – please use the machine in the downstairs waiting room to measure your blood pressure and attach the printout HERE

What is your Height.....
Weight.....
Blood Pressure.....

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FAMILY HISTORY

Do you have a family history of significant illness, for example heart troubles, cancers, stroke, diabetes etc. especially before 60 years? If yes, please give details below.

Relationship		
Age of onset		
Condition and details		
Relationship		
Age of onset		
Condition and details		
Relationship		
Age of onset		
Condition and details		

Next of kin (in case of emergency)

Name		Relation to you:
Address		
Telephone		

Name		Relation to you:
Address		
Telephone		

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SMOKING

Have you ever smoked? Yes ☐ No, ☐ **(XE0on)**
I have never smoked tobacco

If you have smoked:

I used to smoke and have quit ☐ when? _____ **(137F)**

I smoke ☐ how many? _____ a day **(137R)**

If you smoke then you should STOP! (#9NS02)

Would you like help to stop? Yes ☐ **(8H7i)** No ☐ **(8IEo)**

If you are a smoker and you wish to have help stop smoking, please make an appointment with one of our smoking advisors for help and advice.

(Smoking Read Codes start with #137 enter on encounter screen)

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ALCOHOL

Do you drink alcohol? Yes ☐ No ☐

If you drink alcohol, now many units per day? .....
(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)

Fast Alcohol Screening Test (FAST) (#388u)

For the following questions please circle the answer which best applies.

1 drink – ½ pint of beer or 1 glass of wine or 1 single spirits

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than monthly Monthly WeeklyDaily or almost daily

2. 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 WeeklyDaily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly WeeklyDaily or almost daily

4. In the last year has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No Yes, on one occasion Yes, on more than one occasion

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Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved, please tick the box below

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

For Office use : If answered Yes please advise Secretary

Summary Care Records

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. There are leaflets at reception with more information.
This is the national sharing programme (England only)

THIS SECTION IS MANDATORY YOU MUST CHOOSE FROM ONE OF THE OPTIONS BELOW

Expressed Consent	**This will share your medication, allergies and any adverse drug reactions**	
Expressed Consent with additional information	**This will share all of the above plus additional information i.e summary of historical information, Care plans in place, Immunisation history, communication preferences i.e sign language, interpreter etc. Any End of life care plan that may be in place.**	
Expressed Dissent	**This is if you want to actively opt out**	

If you are filling out this form on behalf of another person, please give your name here and circle your relationship with them below:

Your name:	**Parent**	**Legal Guardian**	**Lasting Power of Attorney for Health and Welfare**

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678

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Local Shared Electronic Record

This is a local sharing programme to Devon only

The Local Shared Care Record securely connects different medical and care computer systems together. When your records are requested, it collects the information from the different systems and shows the information to the requester. None of the information it collects is stored by the requester and none of it can be changed by the requester. Because it collects the information only when it is needed, the information always accurately reflects the data as stored on the GP electronic record.

Before any information is collected or displayed to a care professional, that professional must have your consent to view your record. Your consent is recorded on the system so that we know exactly who has accessed what information and when. The GP who holds the original record can see who has viewed it and that you have given consent.

The Local Shared Care Record uses the secure NHS network to retrieve the information and displays a read only view for the care professional to use to support the delivery of care at that specific point in time.

In the case of a medical emergency where the patient is too unwell or unconscious the system will allow the healthcare professional to access the medical record without obtaining explicit consent from the patient if it is thought to be in the best interest of the patient.

For further information please ask at Reception for a leaflet

If you DO NOT wish your electronic record to be shared please circle NO	**No**

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Record Sharing
Managing your data choice

From 25 May 2018 you can choose to stop your confidential patient information being used for purposes other than your own care and treatment. This choice is known as a national data opt-out. If you choose to opt out, NHS Digital will apply your opt-out from 25 May 2018. All other health and social care organisations are required to apply your opt-out by March 2020. Find out more about the national data opt-out.

If you have previously registered an opt-out with your GP practice to request that NHS Digital does not use your confidential patient information (other than for your individual care and treatment), this will have automatically been converted to a national data opt-out on 25 May 2018.

For further information www/nhs.uk/your-nhs-data-matters/ or call 0300 303 5678 (Monday – Friday, 9am – 5pm.

An informed patient, in consultation with a Healthcare Professional, can choose to permit or restrict access to the information entered into their record at each organisation that accesses their record.
The patient will be asked to give their record sharing consent at each organisation at which they receive care.
The patient's consent can be changed at any time by them by logging into their online account and changing their sharing preferences.

Sharing Out

Do you consent to the sharing of data recorded here with any other organisations that may care for the patient?
Please circle Yes/No

Yes	**Share data with other organisations**
No	**Do not share any data recorded here**

Sharing In

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for the patient where the patient has agreed to make the data shareable?
Please circle Yes/No

Yes	**Consent given**
No	**Consent reused**