

Severnbank Surgery

Tutnalls Street, Lydney,
Gloucestershire GL15 5PF
Tel 01594 845715



Patient's details

Mr Mrs Miss Ms

Date of birth.....

NHS Number.....

Town & Country of birth.....

.....

Home address.....

.....

Home Telephone number.....

Mobile No:

Email

Previous Home Address.....

.....

Previous GP Practice.....

I give consent for Severnbank Surgery to contact me via my mobile and agree to notify them of

any number change-

Surname.....

Previous Surname.....

First Names.....

(Known as.....)

Male Female

.....

Post Code

Work No.....

.....

.....

.....

Post Code

.....

If coming from abroad, please tell us your first address in the UK where registered with a GP Practice.....

.....

Date of first arrival in UK.....

Date of leaving if previous UK resident.....

If you were ever registered with an Armed Forces GP, please indicate if you have served in the UK Armed Forces and/or have been registered with a Ministry of Defence GP in the UK or overseas:

Regular Reservist Veteran Family Member

Home Address Before Enlisting

.....

Service or Personnel Number.....

Enlistment Date.....

Discharge Date.....

Do you need Severnbank Surgery to dispense medication and appliances to you? *please note that not all doctors are authorised to dispense medication*

I live more than 1.6km in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

I consent to the information I have given on this application form being held on file under the terms of the General Data Protection Regulation (GDPR) (EU) 2016/679 and I have attached evidence as proof of identity and permanent address

Signature of patient

Signature on behalf of patient

Signature.....Date of Signature.....

Marital Status

Single
Divorced

Single (unmarried)
Widowed

Married
Other

Ethnic Group

- | | | | |
|-------------------------------|--------------------------|---------------------------------|--------------------------|
| British/mixed British | <input type="checkbox"/> | Bangladeshi/British Bangladeshi | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> | Indian / British Indian | <input type="checkbox"/> |
| Other white background | <input type="checkbox"/> | Other Asian background | <input type="checkbox"/> |
| Caribbean | <input type="checkbox"/> | Other Black background | <input type="checkbox"/> |
| African | <input type="checkbox"/> | Other mixed background | <input type="checkbox"/> |
| Chinese | <input type="checkbox"/> | Other white background | <input type="checkbox"/> |
| Pakistani & British Pakistani | <input type="checkbox"/> | White & Asian | <input type="checkbox"/> |
| White & Black African | <input type="checkbox"/> | White & Black Caribbean | <input type="checkbox"/> |
| Ethnic category not stated | <input type="checkbox"/> | Other: | <input type="checkbox"/> |

First Language Other Languages.....

Occupation

Unemployed Retired Full Time Part Time

Number of Children

If in full time education, School/college attended

..... date.....

Next of Kin

Name

Address.....

Home Number

Mobile Number

Relationship to you

Can we contact your Next of Kin in an emergency? Yes No

Can we discuss your medical record with you Next of Kin? Yes No

Is your Next of Kin your main carer? Yes No

Carer Information

Are you a carer (Are you helping look after someone who is frail, ill or has a disability)?

Yes No

If yes, please provide the details of the person for whom you care –

NameRelationship

Address.....

.....Date of Birth

Do you have a carer (Is somebody helping to look after you due to frailty, illness or disability)?

Yes No

If yes, please provide the details of the person who cares for you –

Name Relationship

Address.....

..... Date of Birth

I agree to this information being held on your records. This practice has registered under the General Data Protection Regulation (GDPR) (EU) 2016/679

Signed Date

Health Questionnaire

Do you consider your health to be good?

Yes No

Do you have a clear idea about what sort of food is healthy?

Yes No

Do you exercise regularly?

Yes No

Have you ever smoked?

Yes No

If so, how many per day?

If you have stopped smoking, in which year did you stop?

If you currently smoke, would you like help to quit? Yes No

Smoking is the greatest single cause of illness and death in the UK. We have a support service to help you stop when you are ready. Please ask for an appointment with the Stop Smoking Nurse. You are five times more likely to succeed with help!

How many units of alcohol do you drink per week?

(one unit = 1 glass or wine, ½ pint beer or 1 measure of spirits)

All patients over 16, Please complete the attached Alcohol Questionnaire

How tall are you?

How much do you weigh?

Do you have any disabilities?

Yes (please explain) No

.....
.....

Have you had any operations in the past?

Yes (please list below) No

.....
.....

Do you suffer with or do you have a close family history of any of the following:

(please tick any that apply)

	You	Family history
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Any other major illness	<input type="checkbox"/>	<input type="checkbox"/> (please explain)

Do you take regular medication?

If yes, please list. (If you have a repeat medication order slip, bring it with you to your appointment)

Yes No

.....
.....

Are you allergic to any drugs?

If so, please list

Yes No

.....
.....

Vaccinations

Date of last Tetanus injection

Have you had any other travel immunisations?

If so, please list

.....

This section is for completion by female patients only. Thank you.

Date of last cervical smear test

I agree to attend the surgery for cervical smear tests as recommended by the Cervical Screening Programme.....(signature)

Are you pregnant? Expected Date

Do you use contraception? Yes No

If so which do you use?

- Pill which one
- Coil when was this fitted
- Injection Date of last injection
- Condom

PATIENT INFORMATION SHARING AND CONSENT

All information you give to a member of the practice team is safeguarded by the General Data Protection Regulation (GDPR) (EU) 2016/679 and the NHS Care Record Guarantee. At all times, everyone working for the NHS has a legal duty to keep information about you confidential. However, information is sometimes shared where it is absolutely necessary to support your care or to help improve the service provided by the NHS. **You have a choice about whether your information is shared and for what purpose.** Please tick the boxes below to tell us what your choices are.

<p>Summary Care Record</p> <p>A Summary Care Record contains 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.</p>	<p>Yes- a record will be created for you, but you can opt-out at any time.</p>	<p>No- I wish to decline a Summary Care Record.</p>
<p>Do you want a Summary Care Record?</p>	<p>Yes- <input type="checkbox"/></p>	<p>No- <input type="checkbox"/></p>



Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title Surname / Family name

Forename(s)

Address

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

NHS Number (if known)..... Signature.....

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.....

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 GP practice.

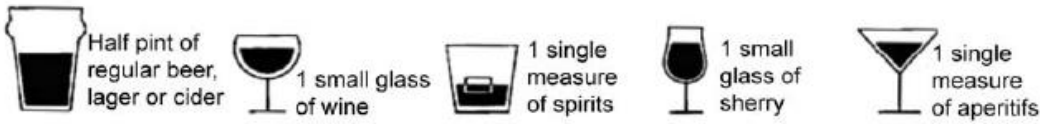
FOR NHS USE ONLY *Add Code 9Ndc*

Actioned by practice: yes / no

Date.....

AUDIT – C

This is one unit of alcohol...



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



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.



Score from AUDIT- C (other side)

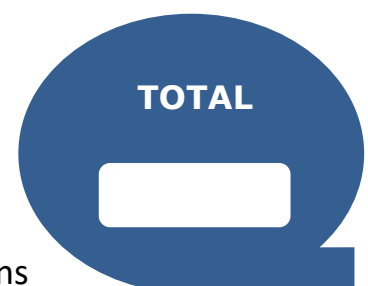


Remaining AUDIT questions

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



We encourage all patients over the age of 5 years to attend for a New Patient Registration appointment. This appointment should be booked with a Nurse if you are not taking regular medication and you are not worried about your health. You should ask for an appointment with a doctor for this check if you are concerned about your health or if you are taking regular medication. This appointment helps us to check your medical history. Please inform the receptionist if you would like to have this check.

Patients at Severnbank Surgery can register for online access to allow them the order their prescriptions, book appointments online as well as see their core record. Please tick the boxes below if you wished to be set up for online access when joining Severnbank Surgery.

- I would like to be set up for online access at Severnbank Surgery
- I would like to be able to order repeat prescriptions online
- I would like to be able to book appointments online
- I would like to be able to see my core record online

All patients are welcomed and encouraged to take part in our Patient Participation Group (PPG). We hold quarterly meetings to give a patient viewpoint on Surgery matters. Would you be interesting in receiving details of the meetings and group activity via the email address you have provided?

- I would like to be involved and consent to be emailed using the address provided
- I would like to be involved but consent to use a different address: _____
- No, I would not like to be involved in the PPG at this time.

Administration Section Only

Allocated/Named GP:

Patient EMIS Number:

New patient screen offered: Y N

NPS offered *Declined*

Appointment booked: Date..... Time.....

Identity Verified:

Patient Access Request

Patient Requested Online Access- Yes No

Online Access Request Completed –

Online Access Details Given- Printed Emailed

Prescription Destination

Previous Prescription Destination removed (if applicable)-

New Prescription Destination added (if applicable)-

I have accepted this patient for general medical services on behalf of the practice

I will dispense medicines/appliances to this patient subject to NHS England approval

Practice Name:

Practice Code:

Practice Stamp: