Reading Walk-In Health Centre

THIS IS A NEW PATIENT REGISTRATION FORM FOR ADULTS

- **THIS FORM IS NOT FOR TEMPORARY REGISTRATION**
- **THIS FORM IS NOT FOR CHILDREN 0-16 YEARS OLD**
- **NEW PATIENTS SHOULD BOOK AN APPOINTMENT AS SOON AS POSSIBLE FOR A HEALTH CHECK WITH A MEMBER OF THE HEALTHCARE TEAM TO ENSURE THAT ANY REQUIRED TESTS ARE UP TO DATE AND THAT WE HAVE AN ACCURATE NOTE OF ANY REPEAT MEDICATION YOU MAY BE TAKING**

WRITE ONLY IN CAPITALS

1. **BRING PROOF OF IDENTITY AND A PHOTOCOPY**
2. **BRING PROOF OF ADDRESS**
3. **COMPLETE A GMS1 FORM**
4. **COMPLETE THIS FORM AND RETURN ALL 8 PAGES**

ONCE YOU HAVE COMPLETED THE NEW PATIENT REGISTRATION FORM PLEASE HAND INTO RECEPTION DURING THE FOLLOWING TIMES:

MON – FRI: 1000am – 1300pm
1500pm – 1800pm

REGISTRATION FORMS WILL NOT BE ACCEPTED AT WEEKENDS

For Official Use Only	Reception Input	Admin Input
Date Completed		
Confirmation of ID & address photocopied		
Provisionally book Mother & baby 6 weeks check (if required)		
Audit C Info	Completed YES/NO	Input YES/NO
Smoking Info	Completed YES /NO	Input YES/NO
Ethnicity Info	Completed YES/NO	Input YES/NO
Alcohol Info	Completed YES/NO	Input YES/NO
Forms Ready For Coding		Completed YES/NO

Reading Walk-In Health Centre

SRCCG.readingwalkinhealthcentre@nhs.net

All Patients to Complete ALL Of The Following Sections + GMS1 Form

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Mobile number: Home Telephone number:

Email address:

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital?

If so please enter details below:

High Blood Pressure	**YES** ☐ **NO** ☐	**Diabetes**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Heart Disease	**YES** ☐ **NO** ☐	**Thyroid Disease**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Epilepsy	**YES** ☐ **NO** ☐	**Stroke / TIA**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Asthma	**YES** ☐ **NO** ☐	**Cancer**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Osteoporosis	**YES** ☐ **NO** ☐	**COPD**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Rheumatoid Arthritis	**YES** ☐ **NO** ☐	**Arthritis**	**YES** ☐ **NO** ☐
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	
Other Illness	**YES** ☐ **NO** ☐	**Surgical / Operation**	
(Please add approximate date of diagnosis if known)		(Please add approximate date of diagnosis if known)	

Mental Health Condition **YES** ☐ **NO** ☐ (Please specify below)

Immunisations ……..

Please bring in a copy of any previous vaccinations

Immunisations	Year	Immunisations	Year
Tetanus		1st MMR (Measles, Mumps or Rubella)	
Typhoid		2nd MMR	
Hepatitis A		Yellow Fever	
Polio		Hepatitis B	

If in doubt, it is recommended you arrange an appointment with the Nurse to have another immunisation as it is quite safe to do so.

Allergies ……

Please list any allergies you have to any drugs/medication/ food:

Type of Allergy	What was the problem or upset?

List of current medications…….

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle …..

Please enter your height & weight:

Height:	Weight:

Lifestyle smoking ……

Do you smoke **YES** ☐ **NO** ☐	**If yes do you smoke:** **Cigarette** ☐ **Cigars** ☐ **Pipe** ☐ **Vape** ☐
Are you an ex-smoker? **YES** ☐ **NO** ☐	**When did you give up?**
How many cigarettes/cigars do you smoke daily? **<1/day** ☐ **1-9/day** ☐ **10-19/day** ☐ **20/39/day** ☐ **40+/day** ☐	
If you smoke a pipe how many ounces a week?	
Would you like help to quit smoking? **YES** ☐ **NO** ☐	

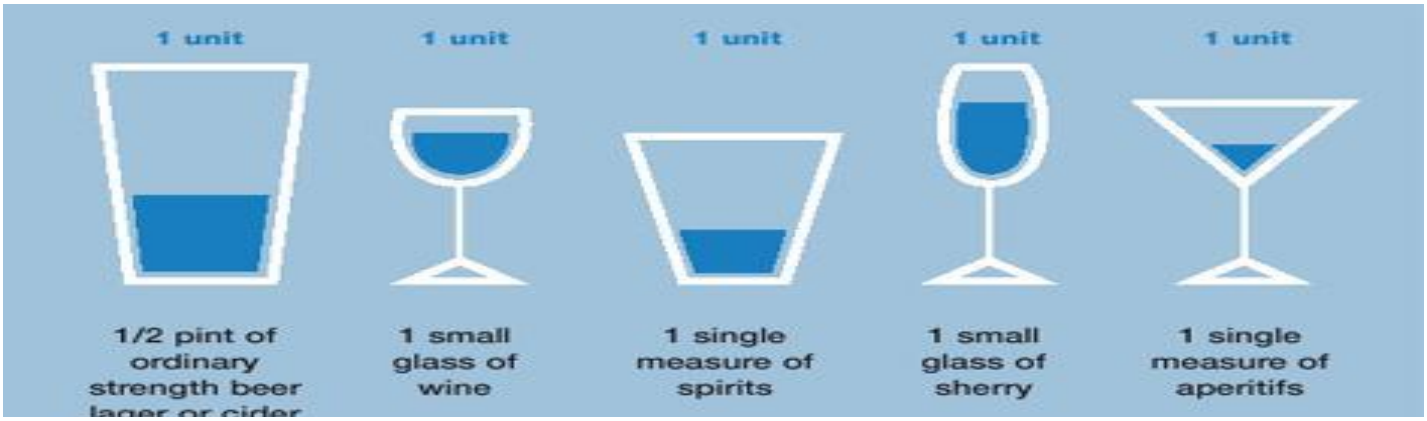
Thinking about Quitting Smoking: Smokefreelife Berkshire is a **free service** from Solutions 4 Health serving Bracknell, Reading, Slough, Windsor and Maidenhead, West Berkshire & Wokingham. They offer support that works! Visit their website at www.smokefreelifeberkshire.com

Lifestyle alcohol ……

Please complete if 18 years or over;

Do you drink alcohol: ☐ **No** *go to page 6 Ethnicity* ☐ **Yes** *If yes answer the following questions;*

This is one unit of alcohol…



ALCOHOL QUESTIONNAIRE 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 or more indicates possible increasing or higher risk drinking.

An overall total score of 5 or above is **AUDIT-C** positive. **If your score is 5 or more please complete the next section for a complete AUDIT-C score**

Remaining AUDIT-C questions (if you scored 5 or more)

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	

Total score, equals AUDIT C Score plus Score of remaining questions above;

Your total Audit Score = _____ (section 1+section 2)

0 -7	indicates sensible or lower risk drinking
8-15	indicates increasing risk drinking
16-19	indicates higher risk drinking
20 and over	indicates possible alcohol dependence

Please make an appointment with our Doctor if your score is 8 or more.

Ethnicity ……

Please indicate your ethnic origin:

☐ White British ☐ White Irish ☐ White Other

☐ Bangladeshi ☐ Black African ☐ Black Caribbean ☐ Pakistani

☐ Mixed White Asian ☐ Mixed White/Caribbean ☐ Mixed White/Black African ☐ Chinese

☐ Other Mixed ☐ Other Black ☐ Other Asian ☐ Other Ethnic Group

Other (please state): _____

Decline to state: _____

What is your first spoken language? _____

Do you need an interpreter? Yes / No

Latent Tuberculosis (TB) …….

Please complete if applicable

Are you 16-35 years old? YES ☐ NO ☐

Did you settle in England within the last 5 years? YES ☐ NO ☐

Have you lived in one of the following countries? Please tick the relevant box

Afghanistan		Burkina Faso		Côte d'Ivoire		Ethiopia		India		Liberia	
Angola		Burundi		Congo (Republic of the)		Gabon		Indonesia		Madagascar	
Bangladesh		Cambodia		DR Congo		Gambia		Kenya		Malawi	
Benin		Cameroon		Djibouti		Ghana		DPR Korea		Mali	
Bhutan		Central African Republic		Equatorial Guinea		Guinea		Lao (PDR)		Moldova	
Botswana		Chad		Eritrea		Guinea-Bissau		Lesotho		Mongolia	
Mozambique		Myanmar		Namibia		Nepal Niger		Nigeria		Pakistan	
Papua New Guinea		Philippines		Rwanda		Senegal		Sierra Leone		Somalia	
South Africa		South Sudan		Swaziland		Tanzania		Thailand		Timor-Leste	
Uganda		Zambia		Zimbabwe							

If you answered yes to these questions, you may be eligible for a free blood test to check for latent TB.

Next of Kin ……

It is important that you give us details of who you would like us to contact in an emergency for example if you are admitted into hospital or you have been involved in an accident.

Please inform us if your next of kin changes.

Full Name: _____

Tel. Contact Number: _____

Relationship: _____

All Patients to Complete, Continued

Online Services ……

Request your repeat prescription and book GP appointments quickly online by logging into your account.

Create account: ⬭ Email Address: _____

I DO NOT want this service ⬭

Female patients only ……

Are you currently, or think you may be pregnant? Yes ⬭ No ⬭

Cervical Smear information

Have you ever had a smear test in the UK? Yes ⬭ No ⬭

Result _____ Date _____

Please contact reception to make an appointment with a Nurse if you require a Cervical Smear Test

Is there any history of Female Genital Mutilation (FGM)? Yes ☐ No ☐ Decline to State ☐

Please tell us about yourself:

Are you an unpaid carer?	**YES** ☐ **NO** ☐
Do you have an unpaid carer?	**YES** ☐ **NO** ☐
If yes, please tell us the name, address & DOB of your Carer or who you care for:	
Are you happy for us to contact your Carer about you?	**YES** ☐ **NO** ☐
If you are a Carer, may we pass your details onto Carer's Hub who offer help & support?	**YES** ☐ **NO** ☐

I give permission for my Carer to have access to my medical records held by the Practice

Signed: _____

Date: _____

Safeguarding Information ……..

Have you ever had an allocated Social Worker?	**YES** ☐ **NO** ☐
If yes, give details	
Are you subject to any form of Care Plan?	**YES** ☐ **NO** ☐
If yes, give details	

By submitting this registration form, you indicate your consent to opting-in for these services. If you do not want to receive the service use the opt-out forms indicated and return it to reception.

Data sharing consent choices

1. NHS England has introduced the **Summary Care Record (SCR)**, which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

   If you wish to **OPT OUT** please complete a SCR Opt-Out form from reception

2. Your mobile number and email address, may be used by the Surgery to contact you for the following reasons:

Text - to send you reminders for appointments, vaccinations, annual reviews, surgery closures etc.

Email- to send you personal letters, surgery newsletters and occasional questionnaires.

If you wish to **OPT OUT** please complete a Text/Email Opt-Out form from reception

I confirm that the information I have provided is true to the best of my knowledge.

Signature ……..……..

Date:

Signature of patient ☐ Signature on behalf of patient ☐

Checklist before coming in to the surgery;

1. Have you completed all relevant sections?
2. Have you signed all relevant sections?
3. Have you completed the GMS1 registration form?
4. Do you have 2 different forms of identification and a copy or your passport?