Thank you for choosing to register with us.

When registering at the practice, ideally we ask for two forms of identification. Please provide a Photo ID (e.g a passport or photo driving licence) or a birth certificate and a current utility bill. We will then be able to register you at the practice.

The information we gather on this form is important as it can take weeks for us to receive your medical records from your previous GP.

Please complete the attached questionnaire in full. The answers to your questions will be confidential and will be entered onto your medical records.

Please ask our Reception team about booking your New Patient Health Check once you have registered. If you have regular repeat prescriptions you will also need to book an appointment with a GP or a clinical pharmacist for a medication review. This helps us to get to know you and your health needs.

Additionally, we want to ensure that you can access and understand information. This applies to patients and their carers who have information and/or communication needs relating to disability, impairment or sensory loss. A small questionnaire is attached below in case you need this registration form in a different format.

If you have any queries about the services we offer you can refer to our website www.parkedgepractice.co.uk, our practice information leaflet or ask a member of our Reception team who will be more than happy to help.

Please use this form to let us know how we can meet your communication needs.

You can ignore this questionnaire if you don't need this form in any other format. Afterwards, you need to send this form completed to our reception or email it to parkedgepractice@nhs.net. We will reply back to you sending this form to the most suitable format based on your answers.

| **Do you need a format other than standard print?** | | |
|---|---|---|
| Require information in easy read? | ☐ YES | ☐ NO |
| Require information verbally? | ☐ YES | ☐ NO |
| Require written info in at least 20 point sans serif font | ☐ YES | ☐ NO |
| Require written info in at least 28 point sans serif font | ☐ YES | ☐ NO |
| Require info in uncontracted (Grade 1) Braille | ☐ YES | ☐ NO |
| Require info in audio format | ☐ YES | ☐ NO |
| Other (please specify): | | |
| **Do you need any support when visiting the Practice?** | | |
| Tactile alerts (e.g. can't see the patient call screen) | ☐ YES | ☐ NO |
| British Sign Language interpreter needed | ☐ YES | ☐ NO |
| Makaton Sign Language interpreter needed | ☐ YES | ☐ NO |
| Other (please specify): | | |

| **For Practice Use only** |
|---|
| All templates completed and reminders set up: |
| Member of staff signed: |
| Date: |

## Personal information

Please complete in capital letters using **black** or **blue** ink and tick the ☐ for any consents or choices applicable to you.

| | | | |
|---|---|---|---|
| Title: | ☐ Mr / ☐ Mrs / ☐ Miss / ☐ Ms | Surname: | |
| Date of Birth: | | First name: | |
| Place of Birth: | | Middle names: | |
| Date first entered UK *(If applicable):* | | Previous Surnames *(If applicable):* | |
| NHS Number: | | Gender: | ☐ Male / ☐ Female / ☐ Other |
| Marital Status: | ☐ Single / ☐ Married / ☐ Widowed / ☐ Co-habiting / ☐ Other | | |
| Current address: | | Post code: | |
| Home Telephone Number: | | Mobile Phone Number: | |
| Email Address: | | | |
| I consent to receiving communications from the Practice to my *landline* via: Calls ☐ / Voice message ☐ | | (You can opt to withdraw consent at any time for any of these options, ask the Receptionist for advice) | |
| I consent to receiving communications from the Practice to my *mobile phone* via: Calls ☐ / Voice message ☐ | | | |
| I consent to receiving communications from the Practice to my email address: ☐ | | | |
| Previous Address: | | Previous Post code: | |
| Name and Address of Previous GP: | | Previous GP post code: | |
| What is your ethnic origin? | | | |
| (We need more information because some illnesses are more common or more severe in people from certain ethnic groups) (e.g.: White British, White European, Asian, Polynesia, Black African, Mixed Race etc.). | ☐ White British / ☐ White European Asian / ☐ Polynesia / ☐ Black African / ☐ Mixed Race / ☐ Other (please state)…….. | | |
| Your main spoken language? | | | |

## About your Health

Please tick the □ for any consents or choices applicable to you.

| ***Smoking Status*** | |
|---|---|
| Never Smoked Tobacco | □ Yes / □ No |
| Are you an Ex-Smoker? | □ Yes / □ No |
| When did you stop? | |
| Are you a current smoker? | □ Yes / □ No |
| How many do you smoke per day? | |

People who stop smoking will see health benefits within days, such as improved taste and smell, while important benefits, such as lower risks of heart attack, stroke, lung cancer and improvements in breathing will happen in the first year or two.
For advice and help with stopping smoking contact Leeds NHS Stop Smoking Service on **0800 169 4219.**

***Alcohol Status***

| **Questions** | **Scoring System** | | | | | **Your Score** |
|---|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** | |
| How often do you have a drink that contains alcohol? | Never | Monthly Or less | 2-4 times Per month | 2-3 times per week | 4+ times per week | |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ | |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

If you have a **score of 5** or over please complete the 2nd part of the questionnaire on the following page.

| ***Alcohol Status***<br>*(To be completed If score of 5 or over)* | | | | | | |
|---|---|---|---|---|---|---|
| **Questions** | **Scoring System** | | | | | **Your Score** |
| | **0** | **1** | **2** | **3** | **4** | |
| 1. 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 | |
| 2. How many units of alcohol do you have on a typical day when you are drinking? | 1-3 | 4-5 | 6-8 | 9-11 | 12+ | |
| 3. How often do you have eight or more units on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 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 | |
| 5. How often during the last year have you failed to do what was normally expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. 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 | |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year. | |
| 10. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year. | |
| **TOTAL SCORE:** | | | | | | |

| Height and Weight | | | | | | |
|---|---|---|---|---|---|---|
| Height<br>*(One entry is necessary)* | | Ft. | | Inches | | |
| Weight<br>*(One entry is necessary)* | | kg | | Stones | | pounds |

| Other | |
|---|---|
| Do you have any medical conditions? | ☐ Yes / ☐ No |
| If yes please give details: | |
| Do you have more than 4 repeat prescription items? | ☐ Yes / ☐ No |
| If yes, please attach a copy of your most recent repeat slip to this form and ask Reception to book your medication review with our Clinical Pharmacist. | |
| Would you like access to online services to book appointments and order repeat prescriptions online?<br>*(If yes please collect your online access login details from the Practice after 7 working days)* | ☐ Yes / ☐ No |
| **Carers Support** | |
| Are you caring for someone such as a family member, partner or friend who needs help because they are ill, frail, disabled or have mental health or substance abuse problems? | ☐ Yes / ☐ No |
| Is the care you provide unpaid? | ☐ Yes / ☐ No |
| Would you like to be recognised and get some support? | ☐ Yes / ☐ No |

| For office use only | | | | |
|---|---|---|---|---|
| Date Received: | | Date Registered: | | ID checked?<br>*(Circle Below)* |
| 4 or More repeat prescription items? Book appointment with Clinical Pharmacist. | ☐ Yes / ☐ No | ☐ Passport / ☐ Driving licence /<br>☐ Bank statement / ☐ Utility bill /<br>☐ Other: …… | | |
| Summary Care record consent | ☐ Yes / ☐ No | | | |

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health such as medicines you are taking, allergies you suffer from and any bad reactions to medicines. You may need to be treated by healthcare professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an SCR means that when you need healthcare you can be helped to recall vital information.

**You can choose to have additional information included in your SCR, which can enhance the care you receive. This includes**

- Illnesses/health problems
- Operations and vaccinations
- Preferences on where you would like to receive care.
- Any support needed.
- Who should be contacted for more information about you.

**You still have the right to opt out of having a SCR which means that:**

- 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:**

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice

Please complete with your details in BLOCK CAPITALS and tick the ☐ for any consents or choices applicable to you.

| ***Declaration*** | | | |
|---|---|---|---|
| **I would like my Summary Care Record to include additional information as listed above** | ☐ Yes / ☐ No | | |
| **I would like to opt out of having an SCR** | ☐ Yes / ☐ No | | |
| If you are filling out this form on behalf of another person, please ensure that you fill out their details. **You** sign the form and provide your details below: | | | |
| Full name of Patient: | | Date of birth: | |
| Patient's Full Address: | | NHS Number (if known) | |
| Patient's Signature: | | Date: | |
| Representative's name (if applicable) | | Representative's Signature (if applicable): | |

Electronic records are kept in all the places where you receive healthcare. Often, NHS care services can usually only share information from those records by letter email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

This service uses a secure computer system that allows the sharing of full electronic records across different NHS care services. This form is **not** about your Summary Care Record (SCR), it is asking your sharing preferences regarding your full detailed electronic record.

We are telling you about this, as you have a choice to make. You can choose to share or not to share your full electronic record with other NHS care services where you are treated and whether we can view records held by those other services.

If you choose to make your record shareable, ***your clinical details will only viewable by clinical teams who are treating you. Each clinical team which cares for you now or in the future will ask your permission to view your shared record.*** You can also ask for part of your record to be made private – not shareable. All record accesses are recorded and auditable.

If you choose not to make your records shareable, we will respect your wishes and will do our best to make your care safe and efficient. However, ***denying the clinical teams caring for you the ability to access important clinical details could compromise your care***.

If you require further information please ask at reception. You can also visit the NHS Care records website at http://www.nhscarerecords.nhs.uk/carerecords or download the NHS Care Record Guarantee from http://www.nigb.nhs.uk/pubs/nhscrg.pdf.

Please tick the ☐ for any consents or choices applicable to you.

| ***Declaration***<br>*How is my decision recorded?* | |
|---|---|
| **Sharing Out** – This controls whether your full electronic patient record can be shared with other NHS care services where you are treated. Please record your preference: | ☐ Yes (Shareable) / ☐ No (not shareable) |
| **Sharing In** – This controls whether you agree for this practice to view information you've agreed to share at other NHS care services. Please record your preference: | ☐ Yes (viewable) / ☐ No (not viewable) |

If you are filling out this form on behalf of another person, please ensure that you fill out their details. **You** sign the form and provide your details below:

| | | | |
|---|---|---|---|
| Full name of Patient: | | Date of birth: | |
| Patient's Signature: | | Date: | |
| Representative's name (if applicable) | | Representative's Signature (if applicable): | |

**PARK EDGE PRACTICE**
**ASKET DRIVE**
**LEEDS**
**LS14 1HX**
Dr Sarah Harding

Dear Patient,

**New service for patients**

You may be aware that all Practices are now required to provide all their patients with a named GP who will have overall responsibility for the care and support that our Practice provides to them.

Your named GP will be appointed and acknowledged to you as soon as we process your information.

**Dr Harding** will have overall responsibility for the care and support that our Practice provides to you. This does not prevent you from seeing any other GP in the Practice, as you currently do.

This letter is for information only. You do not need to take any further action.

Yours sincerely,

**Park Edge Practice**