GRAFTON
MEDICAL PARTNERS

NEW PATIENT REGISTRATION FORM

(Fill Form In Block Letter)

DATE: _____ **TITLE:**_____

(Name as per passport)

FORENAME(S): **MIDDLENAME(S):**

_____ _____

SURNAME(S):

_____

DATE OF BIRTH: **MARITAL STATUS:** **TELEPHONE NUMBER:**

_____ _____ _____

(DD/MM/YYYY)

MOBILE NO: _____

NHS NO: _____
(FIND MY NHS No QR CODE)

EMAIL ADDRESS:

_____

MAIN LANGUAGE SPOKEN **DO YOU REQUIRE AN INTERPRETER?** **DO YOU LIVE IN A NURSING HOME?**

_____ **YES | NO** **YES | NO**

NAME OF NEXT OF KIN (Must Reside in the UK) _____

RELATIONSHIP _____

CONTACT NUMBER _____

ADDRESS _____

_____

WHAT IS YOUR ETHNICITY?

A	**White**	(9i0) British ❑ (9i1) Irish ❑ (9i2) Any other white background ❑
B	**Mixed**	(9i3) White and Black Caribbean ❑ (9i4) White and Black African ❑ (9i5) White and Asian ❑ (9i6) Any other mixed background ❑
C	**Asian or Asian British**	(9i7) Indian ❑ (9i8) Pakistani ❑ (9i9) Bangladeshi ❑ (9iA) Any other Asian background ❑
D	**Black or Black British**	(9iB) Caribbean ❑ (9iC) African ❑ (9iD) Any other black background ❑
E	**Other ethnic groups**	(9iE) Chinese ❑ (9iF) Other ethnic category ❑ (9iG) Not stated ❑

DO YOU WORK? YES | NO

IF SO, WHAT IS YOUR OCCUPATION? _____

HAVE YOU SERVED IN THE ARMED FORCES? YES | NO

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

DO YOU HAVE A CARER? YES | NO

IF YES, WHO? _____

ARE YOU A CARER FOR SOMEONE WHO IS DISABLED OR ELDERLY? YES | NO

IF YES, WHO? _____

ARE YOU ALLERGIC TO ANY DRUGS?

YES_____| NO

ARE YOU ALLERGIC TO ANYTHING ELSE?

YES_____| NO

DO YOU TAKE ANY REGULAR MEDICATION?

_____

_____

_____

HAVE YOU EVER SUFFERED FROM:

HEART ATTACK	YES (Date:_____)	NO
STROKE	YES (Date:_____)	NO
HIGH BLOOD PRESSURE	YES (Date:_____)	NO
DIABETES	YES (Date:_____)	NO
ASTHMA	YES (Date:_____)	NO
EPILEPSY	YES (Date:_____)	NO

DO YOU HAVE ANY SIGNIFICANT FAMILY HISTORY OF ANY SPECIFIC ILLNESSES?

_____

_____

_____

<u>FEMALES ONLY – ALL FEMALES TO COMPLETE</u>

WHEN WAS YOUR LAST CERVICAL SCREENING? (MM/YYYY)

_____

WHAT WAS THE RESULT?

_____

IF YOU HAVE NEVER HAD A CERVICAL SCREENIG, PLEASE TICK HERE ❑

ACCESSIBLE INFORMATION STANDARD

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.

WE WANT TO KNOW IF YOU NEED INFORMATION IN BRAILLE, LARGE PRINT OR EASY READ.

BRAILLE ❑ LARGE PRINT ❑ EASY READ ❑

WHAT IS YOUR PREFERRED METHOD OF CONTACT?

TELEPHONE (LANDLINE) ❑ MOBILE ❑ EMAIL ❑

POST ❑

WE WANT TO KNOW IF YOU NEED AN INTERPRETER.

YES ❑ NO ❑

IF YES, LANGUAGE REQUIRED: _____

WE WANT TO KNOW IF WE CAN SUPPORT YOU TO LIP-READ OR IF YOU USE A HEARING AID.

DO YOU LIP-READ?	YES ❑	NO ❑
DO YOU USE A HEARING AID?	YES ❑	NO ❑

Please note that all of our incoming and outgoing calls are recorded for training and auditing purposes.

PRINT NAME: _____

SIGNED: _____

DATED: _____

ELECTRONIC PRESCRIBING SERVICE (EPS)

The Electronic Prescription Service (EPS) is an NHS service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from.

Repeat of antidepressants?

Please note it is not our general policy to prescribe antidepressants on repeat prescription. We are aware that some practices do this, but we feel this type of medication should be reviewed monthly and will prescribe on an acute basis. Please do not request medication, which has not been added to repeat medication but make an appointment with one of our clinicians 10 days before running out of medication.

What does this mean for you?

If you collect your repeat prescriptions from your GP, you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to the place you choose, saving you time. Your medicines can be collected from a pharmacy near to where you live, work or shop. You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive.

How to order repeat prescriptions?

Please contact your nominated pharmacy at least 7 days before the end of your medications, giving enough of time for your pharmacy and the GP surgery to arrange a repeat prescription at the pharmacy.

How can you use EPS?

You need to choose a place for your GP practice to electronically send your prescription to a pharmacy. This is called a *nomination.*

Can I change my nomination?

Yes, you can. Let us know which is the new pharmacy you want to nominate.

Is EPS reliable, secure, and confidential?

Yes. Your electronic prescription will be seen by the same people in GP practices, pharmacies and NHS prescription payment and fraud agencies that see your paper prescription now.

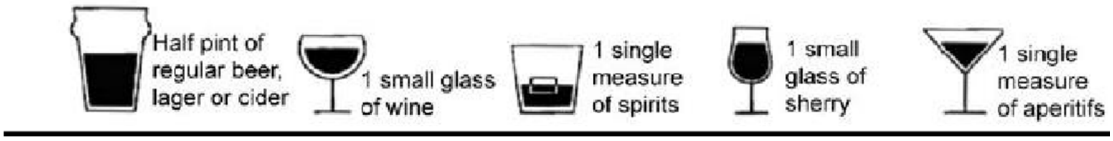
The following local pharmacies offer EPS. Tick to nominate your preferred pharmacy or, alternatively, provide the name and address of an alternative dispenser here:

Barrons Chemist	158A Tooting High Street, Tooting SW17 0RT	☐
Lords Pharmacy	98 Tooting High Street, Tooting SW17 0RR	☐
Boots	59-61 Mitcham Road, Tooting SW17 9PB	☐
Auckland Rogers	892 Garratt Lane, Tooting SW17 0NB	☐
Pearl Chemist	134-136 Mitcham Road, Tooting SW17 9NH	☐
Barkers Chemist	223 Upper Tooting Road, Tooting SW17 7TG	☐
Cospharm	281-283 Mitcham Road, Tooting SW17 9JQ	☐
AP Chemist	129 High Street, Colliers Wood SW19 2HR	☐
Tooting Pharmacy Practice	175 Upper Tooting Road, Tooting SW17 7TJ	☐
Day Lewis	145 Franciscan Road, Tooting SW17 8DS	☐
Sainsbury's Superstore	1 Merton High Street, Colliers Wood SW19 1DD	☐
Boots	Unit 9, The Tandem Centre, Colliers Wood SW19 2TY	☐
Nettles Pharmacy	18 Upper Tooting Road, London SW17 7PG	☐
Trinity Pharmacy	278-280 Balham High Road, Balham SW17 7AL	☐
C Bradbury	86 Moyser Road, Tooting SW16 6SQ	☐
Fairoak Pharmacy	270 Mitcham Lane, Streatham SW16 6NU	☐
Day Lewis	256 Balham High Road, London SW17 7AW	☐
Other (Name & Address)	_____	☐

THE ALCOHOL USE DISORDERS IDENTIFICATION TEST

Because alcohol can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an **x** in one box that best describes your answer to each question.

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 increased or higher-risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SMOKING STATUS

PLEASE TICK **ONE** OF THE OPTIONS BELOW

NEVER SMOKED ☐

EX-SMOKER ☐

CURRENT SMOKER ☐

IF 'CURRENT SMOKER'
HOW MANY A DAY?

_____

APPLICATION FOR ONLINE ACCESS

(Fill Form in Block Letters)

DATE: _____ **TITLE:_____**

(Name as per passport)

FORENAME(S): **MIDDLENAME(S):**

_____ _____

SURNAME(S):

_____

ADDRESS:

_____

DATE OF BIRTH: **MARITAL STATUS:** **TELEPHONE NUMBER:**

_____ _____ _____

(DD/MM/YYYY)

EMAIL ADDRESS:

_____

THIS IS A REQUEST FOR ACCESS:

TO BOOK APPOINTMENTS, REQUEST REPEAT PRISCRIPTIONS AND ACCESS MEDICAL RECORDS

I wish to access my medical record online and understand and agree with each statement:

I will be responsible for the security of the information that I see or download

If I choose to share my information with anyone else, this is at my own risk.

I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement

PATIENT □ ON BEHALF OF PATIENTS (BELOW 16 YEARS) □ :

NAME: _____

SIGNED:

_____

IT IS ESSENTIAL THAT YOU PROVIDE PHOTO ID AND PROOF OF ADDRESS TO ACCESS THIS FACILITY

FOR PRACTICE USE ONLY:

Documents seen as Proof of ID:_____

Documents seen as Proof of Address:_____

(Documents accepted: Passport, Driving license, Utility Bills, Bank Statement, Tenancy Agreement)

IDENTITY VERIFIED BY (STAFF NAME):_____ STAFF INITIAL:_____ DATED:_____

Summary Care Records

Your emergency care summary

Summary Care Record

A Summary Care Record will not contain detailed information about your medical history, but will only contain important health information, such as:

- whether you're taking any prescription medication
- whether you have any allergies
- whether you've previously had a bad reaction to any medication

The only people who can see the information will be healthcare staff directly involved in your care who have a special smartcard and access number (like a chip-and-pin credit card).

The benefits are: For example, a person who lives in London is on holiday in Brighton. One evening, they're knocked unconscious in a car accident and taken to an accident and emergency (A&E) department. Under the current system of storing health records, it would be difficult for A&R staff to find out whether there are any important factors to consider when treating the person (such as any serious allergies to medications), especially as their GP surgery is likely to be closed. If healthcare staff cannot get the relevant health information quickly, some patients may be at risk.

Please **tick ONE** option only:

I **consent** to: Medication, allergies & adverse reactions being held on my SCR ☐

I **consent** to: Medication, allergies, adverse reactions & additional information being held on my SCR ☐

I **dissent** from a SCR being held on my behalf ☐

For Official Use Only

Registration Check list	Tick checked

Check postcode (If patient lives in catchment area)	

GSM form	Name and DOB	
	Town & Country of birth	
	NHS No (If had previous surgery or as per red book)	
	Previous address in the UK	
	Previous GP in the UK	
	Date of entry in UK (If no pervious GP)	
	Signature of parent/carer of the patient on GSM form	

Questionnaire Form	Check if questionnaire is completed	
	Check if pharmacy is nominated(Only one)	

Online Form	Check email address is readable	
	Write the documents seen for proof ID and address	
	Staff name and signature	

SCR form	Check expressed consent/dissent ticked	

Staff Name: _____

Staff initials: _____

Date: _____