# Welcome to South View Partnership

See our practice leaflet, and visit our web site http://www.southviewpartnership.nhs.uk for general information. Please fill in one of these forms for each new patient. We value the information you give us, as it helps us to get to know you, and to understand your health needs better. If you need help or support completing this form, please ask! Thank you

**PLEASE COMPLETE USING BLACK INK AND IN BLOCK CAPITALS** **Tick to confirm ☐**

**PLEASE USE THE BP MACHINE AND ATTACH THE SLIP TO THIS REGISTRATION FORM.** **Tick to confirm ☐**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Personal Identification** | | | | | | Male ☐ Female ☐ |
| Mr ☐ | Mrs ☐ | Ms ☐ | Miss ☐ | Other | NHS No. | |
| Surname | | | | | First Names | |
| Date of Birth | D D / M M / Y Y Y Y | | | | Previous Surname | |
| Town of birth | | | | | Country of birth | |
| Home Address | | | | | Tel (H) | |
| | | | | | (W) | |
| | | | | | (M) | |
| Post Code | | | | | Occupation | |
| Email | | | | | | |
| If applicable, School currently attended: | | | | | | |

**Patient Communication Preferences**

The surgery may need to contact you with regards to appointments, health services, screening etc, Please let us know how you would like us to keep in touch with you

ANY METHOD (mobile/email/text/letter) ☐ (please tick to confirm)

Alternatively, if you would like us to only use a specific method please confirm below;

**How do you communicate?** Please let the surgery know if you require information in a different format; i.e

Large Print / British Sign Language Interpreter / Interpreter (Language _____)

*Please be aware, the surgery website is available in a choice of languages! (translate page)*

| | |
|---|---|
| **If you are from the UK**: | |
| Previous address | Previous Doctor (Name & Address) |
| **If you are from abroad:** | |
| First UK address (where registered with GP) | Date of Entry to UK: |
| | Date Left (if previously resident): |
| **If you are returning from the Armed Forces:** | |
| Address before enlisting: | Service number: |
| | Enlistment Date: |

**Are you a carer? Yes / No**
(If yes, please also complete a 'Carers Identification & Referral form')

**Does someone care for you? Yes / No**

**Carers Name / Contact Number**

**Next of Kin (emergency contact)**

| | | | | |
|---|---|---|---|---|
| Mr ☐ | Mrs ☐ | Ms ☐ | Miss ☐ | Other |
| Name: | | | | |
| Tel: | | | | |
| Home Address: | | | | |
| Post Code: | | | | |
| NOK relationship to you: | | | | |

**Online access**
You can view parts of your medical records, order repeat prescriptions and make routine appointments. Please note you will need to show photo id to finalise this request.

Would like this activated? ☐ Yes ☐ No

**Summary Care Record** – Your Summary Care Record is a summary of your GP medical records. When you are treated away from your usual doctor's surgery, the health care staff can see your medical records which may speed up your care and make sure you are given the right medicines and treatment.
*I consent to share my summary care record* ***YES / NO*** (delete as applicable)
You can share more detailed information by sharing an additional SCR by request;
*I consent to my additional SCR being shared* ***YES / NO*** (delete as applicable)

Further information can be found; https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients

| **Main Spoken Language:** | | | |
|---|---|---|---|
| **Ethnic Origin** | This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. It may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions. Tick here if you do not wish to take part ☐ | | |
| White: | British ☐ | Irish ☐ | Other White ☐ |
| Black: | Caribbean ☐ | African ☐ | Other Black ☐ |
| Asian: | Indian / British Indian ☐ | Pakistani / British Pakistani ☐ | Bangladeshi / British Bangladeshi ☐ |
| | Chinese ☐ | Japanese ☐ | Other Asian ☐ |
| Mixed: | Mixed British ☐ | White & Black Caribbean ☐ | White & Black African ☐ |
| | | White & Asian ☐ | Other mixed ☐ |

**Your Medical Details**

**You -** please confirm if you have, or have ever had, any of the following conditions?

| | | | |
|---|---|---|---|
| Asthma ☐ | Heart disease ☐ | Kidney disease ☐ | Hypothyroidism ☐ |
| Diabetes ☐ | Epilepsy ☐ | Dementia ☐ | Learning disability ☐ |
| Cancer ☐ | COPD ☐ | Depression ☐ | Mental Health problems ☐ |
| | | High blood pressure ☐ | Stroke or TIA (mini stroke) ☐ |

**Family -** please comment if a member has suffered from Cancer, Heart Disease, Stroke, Diabetes, Asthma

*State relationship, disease, type, age*

| **Current health problems** (please list any) | **Past health problems** (illnesses, operations, etc.) |
|---|---|
| | |
| | |
| | |
| | |

**ALLERGIES: Do you have ANY allergies? YES / NO**

**If YES; Please give details:**

**Medications** - please list all that you take (including over the counter or alternative treatments) or include a copy of your repeat prescription list. As a new patient you will need to make a routine appointment to see a GP before any medication can be issued.

| Names of drug/medicine | Dose | Frequency | Why you take it |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Cervical smear tests -** women aged 25 and older only | | |
|---|---|---|
| Date of last smear | Result | Where was the test done? |
| Date next smear | | |

| **Alcohol Consumption**<br>(1 unit = half pint beer = 1 glass wine = 1 measure spirits ) | **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 | |
| | | | | **Total Score** | | |

| **Smoking** | |
|---|---|
| Have you ever been a smoker? | Yes ☐ No ☐ |
| If you currently smoke, how many do you smoke per day? | |
| If you are an ex-smoker, when did you stop? | |
| Your doctors advise all smokers to stop, and free help to do so is available from the surgery, or online at www.smokefreebromley.co.uk | |

**NHS Organ Donor registration** (optional)

Complete this section, call 0300 123 23 23, or register online at:

http://www.organdonation.nhs.uk/how_to_become_a_donor/

0300 123 23 23
organdonation.nhs.uk

*I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death*

Any part of my body ☐ **OR** Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐

Enter your name & date to confirm agreement to inclusion on the NHS Organ Donor Register

| Name | Date |
|---|---|

**NHS Blood Donor registration** (optional)

Are you a blood donor? Yes ☐ No ☐

If you would like to register, call 0300 123 23 23, or register online at:

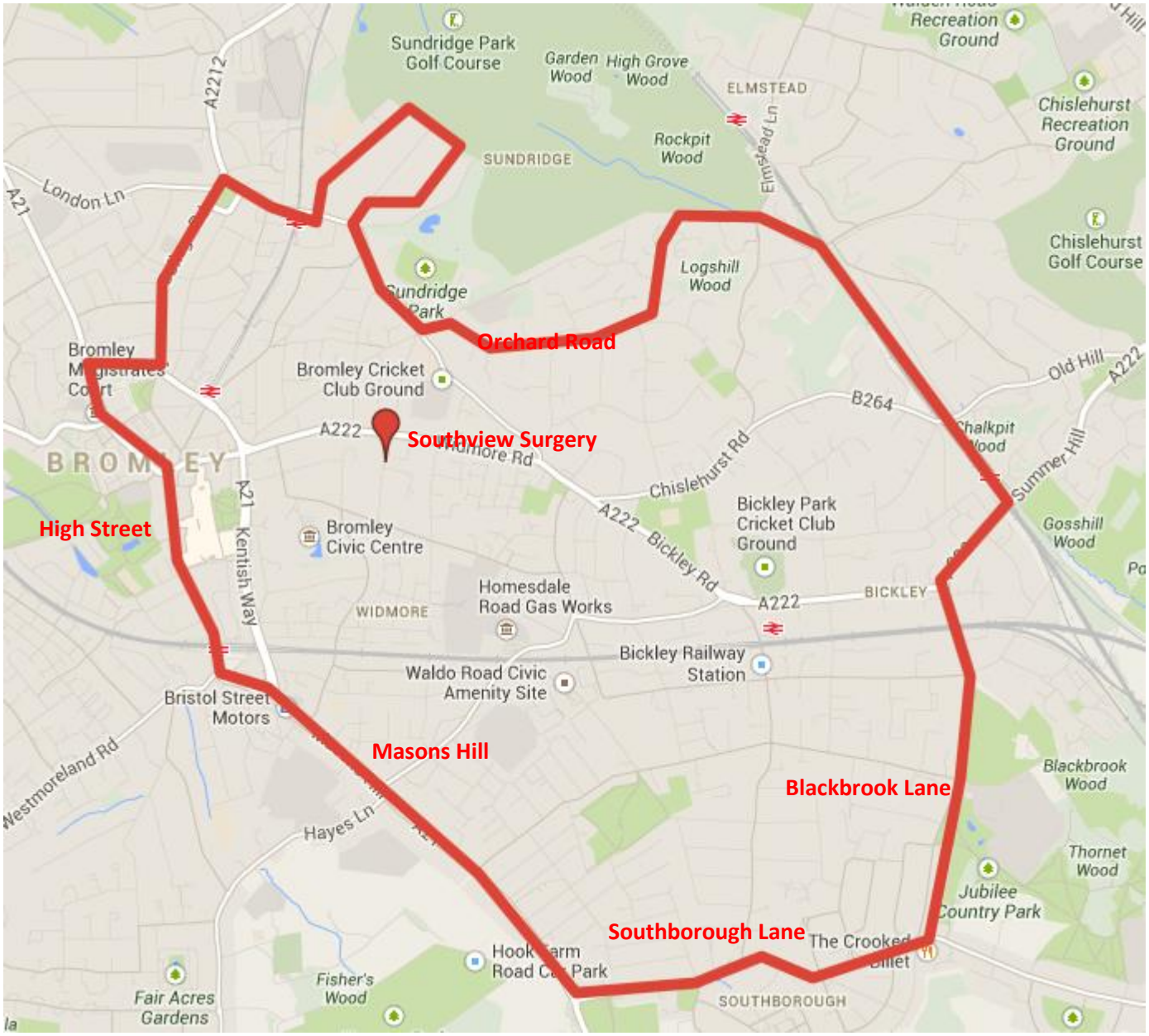
https://secure.blood.co.uk/enrol.asp

Save a life give blood
0300 123 23 23

## Patient Declaration

**Please sign below as confirmation that all the information you have provided on this registration form is correct.**

**Signed: …… Date: ……**




*where applicable

**I have been made aware I am registering under the 'OUT OF AREA SCHEME' and agree to the following;**

- **The surgery has no obligation to provide home visits**
- **The surgery will not provide immediately necessary treatment following an accident or emergency when the patient is at home.**
- **The surgery will not provide follow up care at home following a hospital discharge**
- **The surgery will decide if it is clinically appropriate and practical to accept your out of area registration.**

**Signed: …… Date: ……**