**ASHBY TURN PRIMARY CARE CENTRE**

**Partners**

**Dr J Widders**

**Dr J Sethi**

**Dr N Akhtar**

**Practice Manager**

**Lucy Aisthorpe**



**The Link**

**Scunthorpe**

**North Lincolnshire**

**DN16 2UT**

**Tel 01724 842051**

Welcome to Ashby Turn Primary Care Centre.

As part of the Registration process at this surgery, we require you to complete the attached Registration Form to include your NHS Number. If this is not available, please contact your previous GP to obtain it. New Patient Questionnaire also required to be filled in.

We also require proof of identity – Please supply a Passport, Driving Licence or a recent Utility Bill which shows your address. Bank cards cannot be accepted.

If you have any repeat medication, we will require a copy of your repeat prescriptions. Please ensure you obtain a full month’s prescription from your previous practice before registering with us to ensure you do not run out.

On completion of these forms, if you are on regular medication, please be aware you may need a New Patient Registration appointment with a Health Care Assistant. Reception will advise you of this.

**We will be unable to register you without the above information.**

If you require an urgent prescription, please note that we require 48 hours after your New Registration Appointment to provide this safely.

Yours sincerely,

**ASHBY TURN PRIMARY CARE PARTNERS**

|  |
| --- |
| **ATPCC NEW PATIENT / TEMPORARY RESIDENT REGISTRATION QUESTIONNAIRE ADULT FORM** |
| **Title:** | **Full Name:** | **Preferred Name:** | **Date of Birth:** |
| **Address:** **Post Code:**  |
| **Home Tel: Mobile / Work:****Do you give consent for us to use this mobile number to send text messages? YES / NO** | **NHS number:** |
| **Previous Address (if applicable):** **Post Code:** |
| **Marital Status:** | **Occupation:** |
| **Gender assigned at birth:** | **M / F** | **Sexuality:** | **First Spoken Language:** |
| **Do You Need an Interpreter? Yes / No** | **If so, what language?** |
| **Next of Kin Relationship:** | **Surname:** | **Forenames:** |
| **Address:** **Post Code:** |
| **Home Tel:** | **Mobile / Work:** |
| **Previous GP’s Name:** |
| **Previous GP Surgery Name & Address:** |
| **Do you look after someone who couldn’t manage without you?** | Y / N |
| **CARERS** |
| Are you a Carer? Y / N | Who do you care for? |
| Do you have a Carer? Y / N | Who cares for you? |
| **ARMED FORCES** |
| Are you currently serving in the Armed Forces (regular or reserve)? Y / N |
| Have you ever served in the Armed Forces (regular or reserve)? Y / N |
| **If this is the first time you have registered with a GP surgery since leaving the Armed Forces, please include your FMED 133 form.** |
| **GENERAL HISTORY** |
| **Have you had any serious illnesses or operations? Y / N** |
| **1.** | **3.** |
| **2.** | **4.** |
| **Have you had any of the below illnesses?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please Tick** | **Yes** | **No** | **Medication** | **Yes** | **No** | **List of Current Medication** |
| Asthma |  |  |  |  |  |  |
| Chronic Bronchitis |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |
| Strokes |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |
| Mental Health Problems |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |

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| **PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING. PLEASE PROVIDE A COPY OF THE PRESCRIPTION COUNTER FOIL OR PROVIDE THE MEDICATION BOXES FOR PHOTOCOPY.** |
| **Are you allergic to any medicines or anything else?** |
| **HEALTH PROMOTION** |
| **Smoking status:**  |
| I have never smoked | I stopped smoking in  | I smoke ……… cigarettes per day |
| If you smoke, are you interested in stopping? Y / N (Please ask at reception for further information) |
| **How often do you have a drink containing alcohol?** |
| Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| **How many drinks containing alcohol do you have on a typical day when you are drinking?** |
| 1 or 2 | 3 or 4 | 5 or 6 | 7 or 8 | 10 or more |
| **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 |
| **How often during the last year have you failed to do what was normally expected of you because of drinking?** |
| Never | Less than monthly | Monthly  | Weekly | Daily or almost daily |
| **In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested that you cut down?** |
| No | Yes, on one occasion | Yes, on more than one occasion |
| **Have you now or in the past had problems with substance misuse?**  | Y / N |
| **WE ARE ABLE TO OFFER CONFIDENTIAL SCREENING FOR CHLAMYDIA INFECTIONS FOR**  |
| **PATIENTS AGED 15 TO 25 AS THIS INFECTION OFTEN HAS NO SYMPTOMS. IT IS A SIMPLE** |
| **URINE TEST. THE NURSE CAN DISCUSS THIS WITH YOU IF YOU WISH TO BE SCREENED.** |
| **Y / N** |
| **FAMILY HISTORY** |
| **Please give details of any of your blood relatives, under 65, who have had any of the following:** |
| Heart Disease/Attack |
| Diabetes |
| Asthma |
| Cancer |
| High Blood Pressure |
| Other Serious Illness |
| **VACCINATIONS**  | Please give dates of any vaccinations you have had (if known) |
| Diphtheria | Polio | Tetanus |
| German Measles | Typhoid | Measles |
| Cholera | BCG | Swine Flu |
| Yellow Fever | MMR | Whooping Cough |
| HPV |
| **FEMALE PATIENTS ONLY** |
| Have you had a hysterectomy? Y / N | Date: |
| Which method of contraception are you using at present? |
| Are you interested in discussing Long-Acting Reversible Contraception? Y / N |
| When was your last cervical screening? (If known) | Year: | Result: |
| **SPECIAL COMMUNICATION REQUIREMENTS** i.e Braille or large font type |
| **Ethnic Origin Description** | **Tick appropriate** | **Further Information** |
| White British |  |  |
| White Irish |  |  |
| White European |  |  |
| Asian or British Asian  |  |  |
| Black or Black British |  |  |
| Other - Please state |  |  |
| Mixed - Please state |  |  |

**Please delete as appropriate:**

\*I **Do** / **Do not** agree to share out my medical records with other NHS Health Care Professional

(To ‘share out’ means your medical information recorded here would be viewable by other NHS organisations)

\*I **Do/** **Do not** agree to share in my medical records from other NHS Health Care Professionals

(To ‘share in’ means your medical information recorded at other NHS organisations would be viewable by Ashby Turn Primary Care Centre)

\*I **Do** / **Do not** agree to have a Summary Care Record (SCR) created.

(An SCR shows your name, date of birth, address, current medication and any allergies to other NHS organisations with your consent)

\*I **Do** / **Do not** agree to have a Summary Care Record (SCR) with additional information created.

(Shows your name, date of birth, address, current medication and any allergies. Additional information would show any diagnosis, problems etc)

**SIGNATURE: …………………………………………. DATE: ……………………………**

**To be completed by patients who are 75 years and over ONLY**

All practices are required to provide all their patients aged 75 and over with a named GP who will have overall responsibility for the care and support that our surgery provides to them. They are also entitled to a health check when registering with a new GP practice.

Please tick as appropriate

🞎 I would like to book for a health check 🞎 I do not wish to book for a health check

For admin use only:

**75’s and over**

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Check Booked** |  |  |  |
| **Health Check Declined** |  |  |  |
| **Named GP Letter Given** |  | **Coded (Xab9D)** |  |

**All Patients**

|  |  |
| --- | --- |
| **Repeat Medication Listed** |  |
| **New Patient Check Booked** |  |
| **SCR/Sharing Section Completed** |  |
| **Smoking & Alcohol Section Completed** |  |