The Orchard Surgery Registration Form

Please fill out all sections of the form in BLACK CAPITAL letters

Your named GP is Dr Fouad Guirguis

Incomplete or Illegible forms can delay your registration process so please complete clearly

NHS Number: (Please obtain from you previous surgery if you have previously been registered)	
Title (Mr/Mrs/Miss/Ms)	
Forename (As on passport/birth certificate)	
Surname (As on passport/birth certificate)	
Previous surname (if different)	
Date of Birth	
Place of Birth	
Date of entry to UK if from abroad	
First Language	
Gender	
Marital Status	
Occupation	
Religion	
Ethnicity (please state : white British, white Irish, Indian, Pakistani, Asian, Black African, Black Caribbean, Black – mixed, other)	
Any allergies	
Home Address	Postcode:
Previous Home Address	Previous Postcode:
Telephone Number	Mobile: Home:
Email address	
Previous Doctor Name and Address	

If returning from the armed forces	Your Service Number – Your enlistment date –
Are you a Carer? (please tick**)** NB. A carer is somebody who looks after friends or relations who need support due to frailty, disability or a serious health condition	☐ Yes ☐ No

Are you happy for us to contact you by email or text? (please tick)	☐ Yes ☐ No
Are you happy for us to leave messages for you on your answer phone? (please tick)	☐ Yes ☐ No
Would you like to book appointments, request repeat prescriptions and be able to view a summary of your medical records on-line? (photographic ID needs to be seen)	☐ Yes ☐ No
Would you like to join are Virtual Patient Participation Group and get information and give input about patient services from the practice, and help us improve our services via email? (please provide an email address above)	☐ Yes ☐ No
Would you like to be added to our practice's Whatsapp Group, where we will send information relevant to patient services and health information to you?	☐ Yes ☐ No

Sharing your medical records with others

The NHS would like to share your data with others in a number of ways. Please answer the questions below so that we know how you wish us to share your data.

Summary care records – Sharing In (www.nhscarerecords.nhs.uk)

Ross Road Medical Centre is a part of the national Summary Care Record program. This enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS spine. The summary record can be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline.

Please indicate below whether you would like to have your own Summary Care Record by indicating your decision below (please tick the appropriate box**):**

☐ I wish to have a Summary Care Record containing my medications allergies and adverse reactions or sensitivities to medications

☐ **I** wish to have a Summary Care record with the above **plus** additional important medical information held on my record

☐ **I** do not wish to have a Summary Care Record

Sharing your records with other community health and social care teams – Sharing Out We often work with other clinicians such as district nurses, community midwives, community matrons, health visitors, social services, palliative care. These teams are not employed by our practice but they may need access to your records to support you appropriately. They abide by all of our rules around patient confidentiality. **Are you happy for us to share your records with the community teams?** (please tick the appropriate box)	☐ Yes ☐ No

Who should be contacted in an Emergency for you

Full Forename		
Full Surname		
Contact Number		
Home Address	Postcode:	
Would you like us to discuss your medical record with your emergency contact?		☐ Yes ☐ No
What is the relationship between you and your emergency contact?		

Lifestyle

Smoking (please tick)	☐**I have never smoked** ☐**I used to smoke** (write the date you stopped and how many cigarettes you smoked……) ☐**I am a current smoker** (please write in how many cigarettes you smoke in a day……..) ☐**I am a current smoker and would like help to stop smoking** (please call 0300 123 1044)				
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 units of alcohol do you have on a typical day when you are drinking? (1 pint =2 units minimum)	**1-2** ☐	**3-4** ☐	**5-6** ☐	**7-9** ☐	**10+** ☐

Exercise

Do you regularly exercise? (please circle)	Yes / No
If yes, what sort of exercise?	
On average, how many hours per week?	

Medical Background

Please circle any medical issues you have had / do have	Asthma - Epilepsy - Diabetes - COPD - Stroke - High Cholesterol - Mental Illness - High BP - Heart Disease - Thyroid Disorder - Cancer of_____ Other _____					
What operations have you had and when?						
Do you have any medical problems at present? **Are you happy to be offered a Hepatitis B,C and HIV Test?**						
Please list any tablets, medicines or other treatments you are currently taking: **(incl. dose + frequency)**						
Are you able to administer your own medicines?	Yes			No (please detail specific issues (e.g. swallowing, opening containers)		
What immunisations have you had? (please tick all that apply)	Diptheria	Measels	German Measels	Tetanus	Polio	MMR
	Whooping Cough		Pre-school Booster		Triple Vaccine (diphtheria, tetanus & Pertussis) – 3 doses	

Family Medical Background

Are there any serious diseases that affect your Parents, Brothers or Sisters?

E.g. diabetes, heart attack, bowel cancer, breast cancer, high BP, asthma, stroke, thyroid disorder or any other imp illness

Illness/ Condition			
Family member			
Age diagnosed			

Specific Needs

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any requirements you have, to be able to access the Practice premises		
Please state any Religious or Cultural needs:		
Do you require the help of a Translator / Interpreter?		
Please state any specific nutritional requirements you have:		
Please state any allergies and sensitivities you have:		
Please state any phobias you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	Person Cared For Contact Details:	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	Carer contact details:	
	Signed	Date
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If Yes, can you please bring a copy of it to your New Patient Consultation.*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	*If Yes please state their name/ address / phone number*

Female Patients Only

When was your last smear done?	Date	**Was this at your GP's surgery?** (please circle)	Yes / No
What was the result of the smear?			
Date of last mammogram (if applicable)			
Method of contraception (if used)			
Do you wish to see a someone for contraceptive services (including the pill, coil or cap)?		Yes / No	

Registration and Catchment Area

I understand that:

- **It is my responsibility to arrive for appointments on time and that persistently missing/arriving late for appointments will lead to my deduction (removal from The Orchard Surgery)**
- **It can take up to two weeks for my registration form to be processed; longer if this is the first time I am registering with the NHS**
- **If I am registering a child under 16 years of age, I will need to provide a list of all their immunisations with this form. If I fail to give the list, the child may not be registered or this may cause delay with their registration process**
- **If I do move outside the practice catchment area, I will find a GP practice nearer to my new home immediately. I understand that if I do move outside the catchment area, within the moving process I will not be able to get any home visits from The Orchard Surgery at my new address**

To see if you fall under our catchment area, please see the link on our website under new patient catchment area

Signature	
Date	

Internal Use only **(please sign each section)**

Name of person checking form	
Date form details checked	
Online EMIS access given to the patient – tick when done (need NHS number – if patient does not have NHS number, keep form until it is available)	