CAMBERWELL GREEN SURGERY NEW PATIENT REGISTRATION FORM (4/19)

Practice Email: souccg.camberwellgreensurgery@nhs.net

PLEASE COMPLETE ALL PAGES & PASS TO RECEPTION STAFF

PLEASE USE CAPITAL LETTERS/WORDS – THANK YOU

Number

Surname:	
Forename:	
Date of Birth:	
Title: Miss, Ms, Mrs, Mr, Dr, Rev, Master, etc	
Registered Address with your post code in Camberwell SE5 *please ensure you keep us informed of any changes to your address or contact details* **Note: we can only register patients who live in the local Southwark SE5 post code area**	House / Flat No…… Road/Street Name…… …… CAMBERWELL, LONDON Post Code SE5 …… Access Instructions for GP if needed
For Staff use only **All Households linked on EMIS system**	Staff Initials here when linked on EMIS
Name of a Parent (if under 16) **Mothers Name** **Fathers Name** ***What Relation are you to the child noted as above ?***	
Your NHS Number - *This must be included unless new to the UK*	

ETHNICITY - PLEASE TICK APPROPRIATE BOX

WHITE	**BLACK – OTHER AFRICAN**
WHITE BRITISH	**BLACK – INDIAN SUB CONTINENT**
WHITE OTHER	**BLACK – OTHER**
IRISH	**INDIAN**
GREEK/CYPRIOT	**PAKISTANI**
TURKISH /CYPRIOT	**BANGLADESHI**
OTHER EUROPEAN	**CHINESE**
BLACK AFRICAN	**VIETNAMESE**
BLACK CARIBBEAN	**OTHER ASIAN**
BLACK BRITISH	**OTHER MIXED**
BLACK/ASIAN	**PATIENT REFUSED**
BLACK EAST AFRICAN/ASIAN/INDIAN	**AND NOT RECORDED**

Main Language Spoken	
Interpreter Required	**YES OR NO**
Please provide names of any children and their schools if applicable	
Email Address: *This will help us keep in contact With you*	
Telephone Numbers: *Please ensure you give your Mobile and Home / Land Line number if you have one so we can get in contact with your if urgent*	
What is your preferred method of communication – please tick one	Email: Phone: Letter/Post:
Your Last UK Address when registered with a GP/Dr	
Name of your last GP/Dr in the UK	
Address of your last GP/Dr Surgery in the UK - *this will help us obtain your medical records from your previous GP/Dr Surgery* <u>NOTE: if you have a Registered GP in SE5, we are currently unable to process/accept this registration</u>	
Your Next of Kin Details - *Who is your next of kin – this is normally your husband or wife or partner or mother / father*	Name House/Flat No Street/Road Name Town Post Code Contract Telephone No Relationship of this person to you

Do you consider yourself to have a "Learning Disability?"	
Town and Country of Birth	
Date you came to live in the UK	
Which Country did you arrive from?	
Are you a Carer	**YES OR NO**
Do you have a registered Social Worker attached to your family – if YES please provide Name and contact number of the social worker	
Do you consent to allowing your care and medication records being available to other GP/Dr Practices and hospitals for your personal care only?	**YES OR NO**
Electronic Prescribing Service Would you like your Prescription sent direct from us to a named pharmacy?	**YES OR NO** If yes please give name and address of your preferred pharmacy
Online Services - would you like access to Online Medical services such as access to book your own appointments, to arrange your repeat prescriptions and access your basic medical records?	**YES OR NO** If YES speak to a member of the Reception team for further information
Patient Participation Group (PPG) – would you like to join our Patient Participation Group (PPG) or would you like information to be sent to you on this patient Group	**YES OR NO** If YES speak to a member of the Reception team for further information
Your Signature as the Patient	**……**
Date of your signature	**……..**
Initials of Practice staff member checking this form	

FEMALE PATIENTS ONLY - PLEASE COMPLETE THE FOLLOWING CERVICAL CYTOLOGY DETAILS (if known):

WHERE WAS THE SMEAR TAKEN?

Result if known	
Recall date if known	

Communication Needs – do you have any special communication needs or requirements

YES OR NO

If you are unable to read English or you need your correspondence /letters in another format please let us know in the below

NHS ORGAN DONATION REGISTRATION:

I WOULD LIKE TO JOIN THE NHS ORGAN DONATION REGISTER AS SOMEONE WHOSE ORGANS MAY BE USED FOR TRANSPLANTATION AFTER MY DEATH:

Please tick as appropriate

KIDNEYS [ ] HEART [ ] LIVER [ ] CORNEAS [ ] LUNGS [ ] PANCREAS [ ] ANY PART OF MY BODY [ ]

YOUR SIGNATURE CONFIRMING CONSENT TO ORGAN DONATION:

Sign Here Please …… Date ……

For more information please ask for the leaflet on joining the NHS Organ Donor Register.

NHS BLOOD DONOR REGISTRATION

I would like to join the NHS Blood Donor register as someone who may be contacted and would be prepared to donate blood.

Please tick here if you have donated blood in the past 3 years [ ]

Your Signature giving consent for Inclusion on the NHS Blood Donor Register:

For more information please ask for the leaflet on joining the NHS Blood Donor Register.

Signature ……..... Date .....

ALL NEW PATIENTS - PLEASE COMPLETE FOLLOWING QUESTIONAIRE

NAME: **Male [ ]**		**Female [ ] TICK BOX**	
AGE:		**DATE OF BIRTH:**	
Your Weight: Unknown		**LBs/KGs**	**Height: Unknown**
Your Job or your Occupation:			
Your Housing:	**Type of Accommodation?:**		**Flat**
Your Housing Status:	**Student Accommodation**		

ALL NEW PATIENTS OVER THE AGE OF 14 PLEASE COMPLETE THIS PART ON SMOKING HABITS

SMOKING			
HAVE YOU EVER SMOKED?	[ ] **TICK BOX**	NO [ ] **TICK BOX**	DO YOU SMOKE NOW?
WHAT DO YOU SMOKE			
HOW MANY PER DAY?		IF STOPPED PLEASE GIVE DATE	
HOW MANY GRAMS OF ROLLING TOBACCO PER WEEK		WOULD YOU LIKE TO SEE A SMOKING CESSATION ADVISOR (YES/NO)	
ALCOHOL			
HOW MANY UNITS OF ALCOHOL WOULD YOU DRINK ON AVERAGE IN A WEEK?	**UNKNOWN UNITS**		(1 Unit = Half a Pint of Beer OR 1 glass of wine OR 1 pub measure of Spirits).
DIET			
DO YOU EAT A VARIED DIET INCLUDING MEAT, MILK,VEGETABLES AND FRUIT?		DO YOU ADD SALT TO YOUR FOOD AFTER COOKING?	
EXERCISE			
HOW MANY HOURS OF EXERCISE DO YOU TAKE ON AVERAGE EACH WEEK?		(ONLY INCLUDE EXERCISE THAT MAKES YOUR HEART RACE).	
ILLNESSES THAT RUN IN YOUR FAMILY			
ANGINA		DIABETES	
HEART ATTACK		RAISED BLOOD PRESSURE	

STROKE		RAISED CHOLESTEROL	
HAVE YOU EVER SUFFERED FROM			
HIGH BLOOD PRESSURE		**HIGH CHOLESTEROL**	
WHAT WAS YOUR LAST REVIEW DATE FOR BLOOD PRESSURE			
ASTHMA, BRONCHITIS, FREQUENT CHEST INFECTIONS		**CANCER**	
WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE		WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE	
DIABETES		**MENTAL ILLNESS/DEPRESSION**	
WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE		WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE	
FLU *VACCINATIONS* *- would you like a Flu vaccination (Sep – March) if you suffer from one of the following conditions: Asthma, Diabetes, COPD, Pregnancy, Chronic Kidney Disease, Stroke, Heart Failure, Immuno suppressed*		**YES or NO**	
HEART PROBLEMS		**STROKE**	
WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE			
EPILEPSY			
WHAT WAS YOUR LAST REVIEW DATE FOR THE ABOVE			

THANK YOU – PLEASE CHECK YOU HAVE COMPLETED ALL SECTIONS & PASS TO THE MEMBER OF STAFF

FOR PRACTICE USE ONLY

Name of accepting GP:

Signature of accepting GP:

GPLNS number: **Date of signing:**

HEALTH CHECK:

Offered [ ] Arranged [ ] Completed [ ]

TO BE COMPLETED BY NEW REGISTRATIONS ADMINISTRATOR

All details and information / data given on this form has been uploaded onto EMIS and all admin actions with this registration have been taken and actioned – form will be filed on Docman

Signed..... **Date .....**

New Registrations/Docman Administrator