WOODLANDS PRIMARY CARE
146 HALFWAY STREET, SIDCUP, KENT DA15 8DF
TEL NO 0208 300 1680.
WEB SITE: www.woodlandssurgerysidcup.nhs.uk
Adult Registration Form (16 and over)

FROM JUNE 2015 ALL PATIENTS ARE ALLOCATED TO A GP AS FOLLOWS: A-D DR WALLAT. E-H DR PRIOR. IP DR HACIATURIAN. Q-Z DR BALAJI.
HOWEVER IT DOES NOT MEAN THAT YOU HAVE TO SEE THIS DR.

There is usually a delay in transferring medical records when you change doctors. It would be helpful, therefore if you could answer the following questions. This information is confidential and will be part of your medical records.
If you are interested in online services, please visit our website www.woodlandssurgerysidcup.nhs.uk for more information.

1. REGISTRATION DETAILS

SURNAME -- MARRIED/ SINGLE/ DIVORCED/ WIDOWED/ COHABITING

FORENAMES-- MAIDEN / FORMER NAME________________________

ADDRESS: ____

POSTCODE: ________________ TEL NO. (HOME): ___________________-WORK: ______________________

MOBILE: ______________________ By supplying us with your mobile number you are consenting to the practice sending you text messages

EMAIL ADDRESS: ____

DATE OF BIRTH: ______________________________ OCCUPATION: ______________________________

As of 1st April 2014 If you are aged 75 and over you will be assigned a named GP who will have overall responsibility for the care and support that our surgery provides to them.

Are you moving into the same address as one of our registered patients. YES / No If yes please give details
____

ARE YOU REGISTERED DISABLED? YES / NO

2. ETHNICITY CODING: Please complete the attached form and return to the practice

3. Medical research Data Collection. See attached information If you would like to opt out of this data collection scheme either call 0300 303 5678 or visit nhs.uk/your-nhs-datamatters.
New Patient Medical or NHS Health Checks are available.

4. SMOKING: Do you smoke? YES / NO. Cigarettes / cigars/Pipe. How many per day

Have you ever smoked? YES / NO. how many?___________ When did you stop?_________

5 ALCOHOL: Do you drink alcohol? YES / NO How much per week?_____________

6. EXERCISE: Do you take regular exercise? NONE / GENTLE/ MODERATE/ VIGOROUS

7. Height ________________________ Weight____________________________
Woodlands primary care runs weight management clinics. Would you like some information about our clinic? YES / NO

8. Do you have any CURRENT ILLNESS? YES / NO. Please give details ---------------------------------

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9. Do you have any information or communication needs? YES NO

If yes please state ____

10. MEDICATION: Please give full details of any tablets/ medications taken regularly- and the reason for each. (Please attach a copy of your repeat medication request slip)

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11. ALLERGIES Do you suffer from allergies? YES / NO Details___________________________

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12. Have you had a TETANUS VACCINATION in the last 10 years. YES / No Date________

13. FLU VACCINATIONS: Flu vaccinations are given in the surgery from the end of September. Please ring the surgery for details if you are in an at risk group.

14. FAMILY HISTORY: If you or your family have a history of the following conditions, please tick the appropriate box(es):-

	YOU	PARENT	BROTHER	SISTER
High blood pressure				
Diabetes				
Asthma				
Stroke				
Heart Disease				
High Cholesterol				

15. Female patients only: (a) Please give details of your last CERVICAL SMEAR: DATE________ Result___________

(b) Have you had a MAMMOGRAM? YES/ NO Date: ___________________________

Place: __________________________________Result______________________

(c) Present method of contraception (if applicable)____________________

(d) Female only – how many children do you have? _____________________

16 ARE YOU A CARER? YES / NO. do you give extra help to your spouse, partner, parent, child or friend because they are ill, disabled or frail? We can connect you with information and support. DOES THE PERSON YOU CARE FOR BELONG TO THIS SURGERY? YES / NO

IF YES, HIS / HER NAME IS: _________________________ DATE OF BIRTH_______________________

ADDRESS:____

Bexley NHS Care Trust

HELP US TO HELP YOU:
IMPORTANT INFORMATION REQUIRED BY YOUR DOCTOR

Dear Patient,

Staff at your Doctor's Surgery are working to make services better for all.

By answering the questions in this form you will be helping us to deliver better services to you as an individual. We will also get a better picture of the local population and this will help in planning new services and improving existing ones so that we can better meet the needs of all sections of the community.

The information you provide will be treated in the strictest confidence and treated in the same way as your health records which are legally protected by the data protection act.

Only named staff here at your Surgery will use this personal information.

When used in the planning of services all names and other identifying details will be removed. If you have any queries please contact the Surgery and we will answer your questions.

First Name: ________________________ Surname:______________________ D.O.B ____/____/_____

House Number: ______Street:-__________________________________ Postcode:______________

Telephone: __________________________ Mobile: _________________________________

How would you describe your Ethnic Group? (These are the Office of National Statistic Categories)

White and White British

- ☐ White British (A) **9i0**
- ☐ White Irish (B) **9i1**
- ☐ White Other (C) **9i2**

Mixed

- ☐ Mixed White & Black Caribbean (D) **9i3**
- ☐ Mixed White & Black African (E) **9i4**
- ☐ Mixed White & Asian (F) **9i5**
- ☐ Mixed Other (G) **9i6**

Asian and Asian British

- ☐ Asian Indian (H) **9i7**
- ☐ Asian Pakistani (J) **9i8**
- ☐ Asian Bangladeshi (K) **9i9**
- ☐ Asian Other (L) **9iA**

Black and Black British

- ☐ Black Caribbean (M) **9iB**
- ☐ Black African (N) **9iC**
- ☐ Black Other (P) **9iD**

Other Ethnic Categories

- ☐ Chinese / British Chinese (R) **9iE**
- ☐ Other Ethnic Cateogry (S): Pls write in: **9iF** ____________________
- ☐ Not Stated (Z) **9iG**

Main language spoken ___________________________

Do you require the services of an Interpreter / Translator? ☐ Yes ☐ No

Request for my clinical information to be withheld from Bexley Linked Care

*If you **DO NOT** want a Bexley Linked Care record please complete the form below and send it to your GP practice.*

A. Please complete in BLOCK CAPITALS

Title: .... *Surname / Family Name:*..

Forename(s): ....

Address: ....

Postcode:........................ *Phone No:*..

Date of birth: .... *NHS Number (if known):* ....

Signature: .... *Date:*..

B. If you are completing this form on behalf of another person or a child, the GP practice will consider this request.

Please ensure you complete their details in section A and your details in section B

Your name: .... *Your signature:*..

Relationship to patient: .... *Date:* ....

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title .... Surname / Family name ....

Forename(s) ....

Address ....

Postcode .... Phone No .... Date of birth ....

NHS Number (if known) .... Signature ....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name .... Your signature ....

Relationship to patient .... Date ....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date ....

Ref: 4705

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use 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. E.g.:
0 = Never;
1 = Monthly or less;
2 = 2-4 times a month;
3 = 2-3 times a week;
4 = 4 or more times a week

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?					
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
3. How often do you have six or more drinks on one occasion?					
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
5. How often during the last year have you failed to do what was normally expected of you because of drinking?					
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?					
7. How often during the last year have you had a feeling of guilt or remorse after drinking?					
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?					
9. Have you or someone else been injured because of your drinking?					
10.Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?					
RECORD TOTAL OF SPECIFIC ITEMS HERE					