Lyndhurst Surgery

2 Church Lane, Lyndhurst, Hampshire SO43 7EW

**Phone:** 02380 282689 **Email:** [whccg.lyndhurstsurgery@nhs.net](mailto:whccg.lyndhurstsurgery@nhs.net)

**Website:** [www.lyndhurstsurgery.org.uk](http://www.lyndhurstsurgery.org.uk)

**NEW PATIENT REGISTRATION FORM – aged 16 plus**

**About You**

Title: ……. Surname: ………………………… Forename(s): ………………………………………….

Do you have a preferred name (eg Jennie vs Jennifer)? .................................................................................

Previous Surname: ………………………………………. Date of Birth: ………………………...........................

Gender: ……………………………………………………. NHS Number: ……………………………..…………..

Town and country of Birth **…………………………………………………………………………………**

**Contact Information**

Address:…………………………………………………………………………………………………………………..

Post Code: ………………………………………………… Telephone: …………………………………………….

Mobile: ……………………………………………………... Email: …………………………………………………..

**Previous GP details in the UK**

Previous home address in the UK ………………………………………………………………….………………..

……………………………………………………………………………….……………………………..……………..

Previous GP Name & Practice Address: ….………………………………………………………………………………………………………………………….

…………………………………………………………….........................……………………………………………..

**If you have served in the UK Armed Forces and have been registered with an MoD GP please see a receptionist to complete a GMS1**

**If you are from abroad**

Your first UK address where registered with a GP ……………………………………………………………

……………………………………………………………………………………………………………………….

If previously resident in the UK what date did you leave? …………………………………………………

Date you first came to live in the UK. …………………………………………………………………….

**If you are not ordinarily resident in the UK you MUST complete the last page of this registration form**

**Service Families and Military Veterans**

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** currently serving in the Reserve Forces |  | **I AM** a Military Veteran |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  |  |  |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. |  | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. |  |

Date of discharge (if applicable): ……………………………………………………………………………………...

**Students**

Are you studying in the UK on a student visa? **Yes  No**

Have you moved address due to starting a higher education course? **Yes  No**

If yes to either of the above questions, please provide your course dates:

Start: ……………………………………………………….. Finish: ………………………………………………….

**Ethnicity**

Having information about patients’ ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients’ needs. If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| British or mixed British |  | Pakistani |  |
| Irish |  | Bangladeshi |  |
| African |  | Chinese |  |
| Caribbean |  | Other (please state): |  |
| Indian |  |  |  |

**Main Language**

Which is your main language? ..........................................................................................................................

Do you speak English? .....................................................................................................................................

Do you need a translator? ……………………………………………………………

**Carer Status**

Are you yourself a carer? **Yes  No**

*If yes, please ask reception for a ‘Carer pack’’.*

Do you have a carer? **Yes  No**

If yes, please provide their:

Name: …………………………………………………….... Relationship to you: ……………………………….....

Are they a patient here? **Yes  No**

Can we discuss any aspect of your medical record with your carer? **Yes  No**

*If yes, please ask reception for a ‘Third Party Consent Form’*

**Next of Kin (For Emergency Contact)**

Surname: …………………………………………………... Forename(s): ………………………………………….

Gender: ……………………………………………………. Relationship to you: …………………………………..

Telephone: ………………………………………………... Mobile: ………………………………………………….

Can we discuss any aspect of your medical record with your next of kin? **Yes  No**

*If yes, please ask reception for a ‘Third Party Consent Form’*

**Marital Status**

Please indicate your marital status by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| Single |  | Widowed/Surviving Civil Partner |  |
| Married/Civil Partner |  | Other (please state): |  |
| Divorced/Civil Partnership dissolved |  |  |  |
|  |  |  |  |

**Contacting You**

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Do you consent to the Surgery sending text messages to your mobile? **Yes  No**

Do you consent to the Surgery sending messages to you by email? **Yes  No**

Do you consent to the Surgery leaving messages on your phone? **Yes  No**

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Please select your preferred choice of contact: **Text  Phone  Email  Post**

**Record Sharing**

Lyndhurst Surgery would like to hold, process, and share your personal and medical records, manually and electronically, as outlined below. For more information visit [GDPR - Your Data - Lyndhurst Surgery](https://www.lyndhurstsurgery.org.uk/gdpr---your-data)

**EMIS Sharing**

Locally for the purposes of the Local Shared Electronic Record (CHIE) and the OOH Hub for my direct health care.

**Opt In  Opt Out**

**Summary Care Record**

Nationally for the purposes of National Shared Electronic Record (SCR) for my direct health care.

**Opt In  Opt Out**

**National data opt-out**

This means that a Patient’s data **will be shared with NHS Digital** but **will not be used for Planning or Research**. How to apply this opt out – The patient must go online to ‘Your Data Matters’ <https://ico.org.uk/your-data-matters/> or telephone them to apply their own preferences - **0300 303 5678**. The GP practice cannot do this for you.

Signed: ……………………………………………….......... Date: …………………………………………………..

Print name: ………………………………………………………………………………………………………………

**Please note** – We use partner software suppliers/businesses who may have access to specific parts of your data (e.g., to send letters/text reminders). We have gained approval from West Hampshire CCG to use these companies and we are confident your data is secure. If you would like to view who our software suppliers/businesses are and what information they can see please visit

[GDPR - Your Data - Lyndhurst Surgery](https://www.lyndhurstsurgery.org.uk/gdpr---your-data)

We do not share your data for the purposes of education, research, audit or administration without your express consent (i.e., we would ask you every time for permission before doing this). The only exception to this would be where the data was anonymised, i.e., not identifiable back to you.

**Electronic Prescribing Service (EPS)**

Please nominate a pharmacy below for all your regular prescriptions to be sent for collection.

Nominated pharmacy: ………………………………………………………………………………………………….

Postcode: ………………………………………………………………………………………………………………...

If you know you need a separate appliance pharmacy, please nominate below:

Nominated appliance pharmacy: ……………………………………………………………………………………...

Postcode: ………………………………………………………………………………………………………………...

**Donation Wishes**

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.

If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit: <https://www.organdonation.nhs.uk/register-your-decision/do-not-donate/>

Do you have a donor card or are you on the organ donation register? **Yes  No**

Have you opted out? **Yes  No**

Do you donate blood? **Yes  No**

**Resuscitation Wishes and Power of Attorney**

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes  No**

Does anybody hold Lasting Power of Attorney for Health and Welfare for you?

**Yes  No**

*If yes to either of the above questions, please supply details of who holds this and where (and supply a copy with this form for your medical notes).*

Details…………………………………………………………………………………………………………………….

**Smoking Status**

Do you smoke? **Yes  No**

If yes, how many cigarettes do you smoke daily: ……..…………………………………………………………….

If no, have you smoked in the past? **Yes  No**

Do you use electronic cigarettes/vape? **Yes  No**

Smoking is the UK’s single greatest cause of preventable illness.

Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.

*If you would like help and advice on how to give up smoking, please contact* [*https://www.smokefreehampshire.co.uk/*](https://www.smokefreehampshire.co.uk/) *or ask at reception.*

**Blood Pressure**

If you have a home blood pressure monitor please provide an up-to-date reading below:

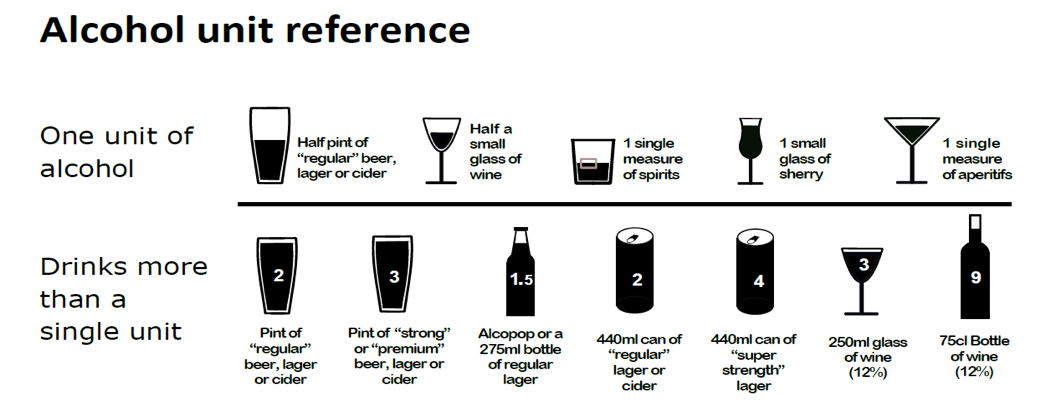
B/P: …………………………………………………………. Pulse: …………………………………………………

Date taken: ………………………………………………………………………………………………………………

**Alcohol Intake**

Do you ever drink alcohol? **Yes  No**

If yes, how many units a week do you drink on an average week? ……………………………………………….



**Exercise**

Please indicate your exercise status by ticking one box below:

|  |  |  |  |
| --- | --- | --- | --- |
| Exercise physically impossible |  | Enjoys moderate exercise |  |
| Avoids even trivial exercise |  | Enjoys heavy exercise |  |
| Enjoys light exercise |  | Competitive athlete |  |

**Weight/Height**

What is your weight? ……………………………………………………………………………………………………

What is your height? ………………………………………………………………………………………………...….

*If you would like advice on managing a healthy weight, please contact* [*https://www.nhs.uk/live-well/*](https://www.nhs.uk/live-well/) *or reception who will be able to direct you to the most appropriate service.*

**AUDIT-C**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 alcoholic drinks do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

Score: …………………………..

*If you would like help and advice on how to reduce your alcohol intake, please contact* [*https://www.drinkaware.co.uk/*](https://www.drinkaware.co.uk/) *or ask at reception.*

**Disabilities / Accessible Information Standards**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs? **Yes  No**

If yes,please state your needs: ……………………………………………………………………………………….

……………………………………………………………………………………………………………………………..

Are you blind/partially sighted? **Blind  Partially sighted**

Do you have significant problems with your hearing? **Deafness**  **Hearing difficulty**

Do you have significant mobility issues? **Yes  No**

If yes, are you housebound? **Yes  No**

*(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)*

**Family History and Past Medical History**

Have any close relatives (parent, sibling or child only) ever suffered from any of the following? **Who (e.g. Father)?**

Heart disease (heart attack/angina) **Yes  No** ...............................

*If yes, what age were they at onset?* **< 60 yrs.  ≥ 60 yrs.**

Asthma **Yes  No** ..................................

Hypertension **Yes  No** ……………………..

Diabetes mellitus **Yes  No** ……………………..

Stroke **Yes  No** ……………………..

Rheumatoid arthritis **Yes  No** ……………………..

Cancer **Yes  No** ……………………..

Epilepsy **Yes  No** ……………………..

Osteoporosis **Yes  No** ……………………..

Glaucoma **Yes  No** ……………………..

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medications**

Please provide a list of repeat medications you take: ………………………………………………………………

……………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………..

**Allergies**

Please list any drug or food allergies that you have: ……..…………………………………………………………

……………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………..

**For Female Patients Only**

Have you had a cervical smear test? **Yes  No**

If yes, when was this last done and what was the result? ………………………………………………………..

……………………………………........................................................................................................................

Have you had a hysterectomy? **Yes  No**

Do you still have your ovaries? **Yes  No**

Are you currently pregnant? **Yes  No**

*If yes, please ensure you are under the care of a midwife. If you’re not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present? ………………………………………………..

……………………………………………………………………………………………………………………………..

If you have an implant/coil, when was this fitted? ...…………………………………………………………………

**Consent**

**I consent that the information given is true to the best of my knowledge.**

Signed: ……………………………………………….......... Date: …………………………………………………..

1

Print name: ………………………………………………………………………………………………………………

**Identification**

Please make sure that you bring 2 forms of identification with you when returning your registration form. E.g., Photo driving licence, utility bill confirming your new address.

Staff name checking identification: ……………………………………………

Identification seen: ……………………………………………………………..

Date: ……………………

**ONLINE SERVICES**

Patients can register for online services to manage their appointments, repeat prescriptions, and view their medical records.

Patients that have signed up to this service with their previous surgery, will need to complete the process again. Please speak to the reception team.

There are several applications which can be used to register. If you are over 13, and have a smart phone or tablet, the preferred way is to use the **NHS App**.

**APPLE USERS:**

Scan this QR code:

OR

Go to the App store and search for the NHS App

**ANDROID USERS:**

Scan this QR code:

OR

Go to the Play store and search for the NHS App

You will then be able to self-register on the app by uploading a photo of your ID and recording a short video.

If you don’t have a smartphone or tablet, or don’t wish to use the NHS App, please contact reception to arrange a video ID verification call with a member of our IT Team.

**Only complete this section if you are not ordinarily resident in the UK**

****