Graphical user interface, text, application

Description automatically generated

**Partington Family Practice, Partington Health Centre, Central Road, Partington, M31 4FY**

**Phone:** 0161 775 7033 **Email:** [clinical.partingtonfamily@nhs.net](mailto:clinical.partingtonfamily@nhs.net)

**Website:** [www.drdeweeverandpartners.co.uk](https://www.drdeweeverandpartners.co.uk/)

**NEW PATIENT REGISTRATION FORM**

**About You**

|  |
| --- |
| Title: Choose an item. Other: Click or tap here to enter text. |
| Surname: Click or tap here to enter text. |
| Forename(s): Click or tap here to enter text. |
| Do you have a preferred name (eg Jennie vs Jennifer)? Click or tap here to enter text. |
| Previous Surname: Click or tap here to enter text. Date of Birth: Click or tap here to enter text. |
| Gender: Click or tap here to enter text. NHS Number: Click or tap here to enter text. |
| Previous GP Practice: Click or tap here to enter text. |

**Contact Information**

|  |
| --- |
| Address:Click or tap here to enter text. |
|  |
| Post Code: Click or tap here to enter text. Telephone: Click or tap here to enter text. |
| Mobile: Click or tap here to enter text. Email: Click or tap here to enter text. |

**Residency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you live in a residential/nursing home? | **Yes** |  | **No** |  |
| Do you have a door access key code you would like kept on record? Click or tap here to enter text. |
| Previous address in the UK (if applicable): Click or tap here to enter text. |
|  |
|  |
| If you are from abroad, what date did you come to UK? Click or tap here to enter text. |

**Occupation**

What is your occupation? Click or tap here to enter text.

**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** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran |  |
| **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): Click or tap here to enter text.

**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:Click or tap here to enter text. Finish: Click or tap here to enter text.

**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 |  |  |  |

**Religious Affiliation**

Do you have a religious affiliation (please give details if so)? Click or tap here to enter text.

**Place of Birth**

|  |
| --- |
| In which Country and City were you born? Click or tap here to enter text. |

**Main Language**

|  |
| --- |
| Which is your main language? Click or tap here to enter text. |
|  |
| Do you speak English? Click or tap here to enter text. |

**Carer Status**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you yourself a carer? | **Yes** |  | **No** |  |
|  |  |  |  |  |
| Do you have a carer? | **Yes** |  | **No** |  |
| If yes, please provide their: |  |  |  |  |
| Name: Click or tap here to enter text.  Relationship to you: Click or tap here to enter text. |  |  |  |  |
|  |  |  |  |  |
| Are they a patient here? | **Yes** |  | **No** |  |
| Can we discuss any aspect of your medical record with your carer? | **Yes** |  | **No** |  |
|  |  |  |  |  |

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

|  |
| --- |
| Surname: Click or tap here to enter text.  Forename(s): Click or tap here to enter text. |
|  |
| Relationship to you: Click or tap here to enter text. |
|  |
| Telephone: Click or tap here to enter text. Mobile: Click or tap here to enter text. |
|  |
| Can we discuss any aspect of your medical record with your next of kin? | **Yes** |  | **No** |  |

**Marital Status**

Please indicate your marital status by ticking the below box:

|  |  |  |  |
| --- | --- | --- | --- |
| Single |  | Civil partnership dissolved |  |
| Married |  | Widowed |  |
| Civil partner |  | Other (please state): |  |
| Divorced |  |  |  |

**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**

Partington Family Practice would like to hold, process and share your personal and medical records, manually and electronically, as outlined below

**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**

**Research**

Nationally for the purposes of improving and planning the health and care of current and future generations (indirect health care)

**Opt In  Opt Out**

Signed:Click or tap here to enter text. Date: Click or tap here to enter text.

Print name: Click or tap here to enter text.

**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 Trafford CCG to use these companies and we are confident your data is secure.

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: Click or tap here to enter text. |
|  |
| Postcode: Click or tap here to enter text. |
|  |
| If you know you need a separate appliance pharmacy please nominate below: |
|  |
| Nominated appliance pharmacy: Click or tap here to enter text. |
|  |
| Postcode: Click or tap here to enter text. |

**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 Click or tap here to enter text.

**Smoking Status**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? | **Yes** |  | **No** |  |
|  |  |  |  |  |
| If yes, how many cigarettes do you smoke daily: Click or tap here to enter text. |  |  |  |  |
|  |  |  |  |  |
| 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:

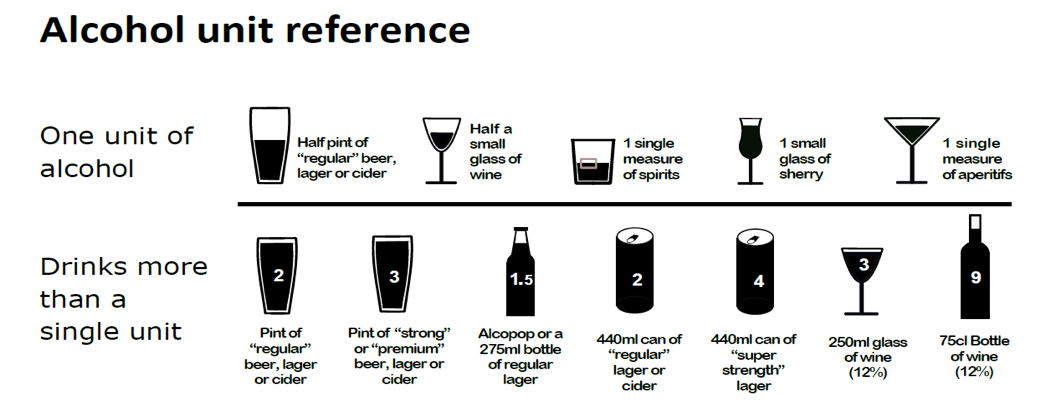
B/P: Click or tap here to enter text. Pulse: Click or tap here to enter text.

Date taken: Click or tap here to enter text.

**Alcohol Intake**

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

If yes, how many units a week do you drink on an average week? Click or tap here to enter text.



**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? Click or tap here to enter text.

What is your height? Click or tap here to enter text.

*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.*

***G*eneral Practice Physical Activity Questionnaire**

1. Please tell us the type and amount of physical activity involved in your work.

|  |  |  |
| --- | --- | --- |
|  |  | **Please mark one box only** |
| a | I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.) |  |
| b | I spend most of my time at work sitting (such as in an office) |  |
| c | I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.) |  |
| d | My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.) |  |
| e | My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.) |  |

1. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

**Please mark one box only on each row**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **None** | **Some but less than**  **1 hour** | **1 hour but less than**  **3 hours** | **3 hours or more** |
| a | Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc. |  |  |  |  |
| b | Cycling, including cycling to work and during leisure time |  |  |  |  |
| c | Walking, including walking to work, shopping, for pleasure etc. |  |  |  |  |
| d | Housework/Childcare |  |  |  |  |
| e | Gardening/DIY |  |  |  |  |

1. How would you describe your usual walking pace?

|  |  |  |
| --- | --- | --- |
|  |  | **Please mark one box only** |
| a | Slow pace (i.e. less than 3 mph) |  |
| b | Steady average pace |  |
| c | Brisk pace |  |
| d | Fast pace (i.e. over 4mph) |  |

**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: Click or tap here to enter text.

*If your score is less than 5 please proceed to the ‘Disabilities / Accessible Information Standards’ section.*

*A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | 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 from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 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 |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |

Total Score (including the score above):Click or tap here to enter text.

*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: Click or tap here to enter text. |  |  |  |  |
|  |  |  |  |  |
| 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** Click or tap here to enter text.

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

Asthma **Yes  No** Click or tap here to enter text.

Hypertension **Yes  No** Click or tap here to enter text.

Diabetes mellitus **Yes  No** Click or tap here to enter text.

Stroke **Yes  No** Click or tap here to enter text.

Rheumatoid arthritis **Yes  No** Click or tap here to enter text.

Cancer **Yes  No** Click or tap here to enter text.

Epilepsy **Yes  No** Click or tap here to enter text.

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?** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Medications**

Please provide a list of repeat medications you take: Click or tap here to enter text.

**Allergies**

Please list any drug or food allergies that you have: Click or tap here to enter text.

**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? Click or tap here to enter text. |  |  |  |  |
|  |  |  |  |  |
| 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 are 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? Click or tap here to enter text. |  |  |  |  |
|  |  |  |  |  |
| If you have an implant/coil, when was this fitted? Click or tap here to enter text. |  |  |  |  |

**Consent**

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

Signed:Click or tap here to enter text. Date: Click or tap here to enter text.

Print name: Click or tap here to enter text.

**ONLINE SERVICES**

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

There are a number of 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.