THE ROYAL DOCKS MEDICAL PRACTICE

ADULT REGISTRATION FORM – ADULTS 16 years and older

This notice gives you details about registering as a patient with us. You must register in person. **PLEASE READ IT CAREFULLY.**

Before we accept you as our patient (even if you have been registered with us before) you will need to show us **two** forms of identification.

One of these must be a **photo ID e.g. driving licence, birth certificate for under 16 years old. or**

Documents also needed:-

One must be an **official document (any utility bill e.g. gas, electric, water, council tax, bank statements, any government agency letter or landline telephone bill)** no more than **three months old** that will prove that you live inside our practice boundary. Tenancy agreements and mobile phone bills are **not** acceptable.

If you have been previously registered with a GP in the UK, you will need to obtain your **National Health Service number (NHS Number).**

If you are on any medication, you **will** be required to have a new patient health check. To cancel your appointment for any reason, please call us on **020 7511 4466**

If you are aged 16 to 64 years, you are eligible for free HIV screening as part of a new patient health check, this is an optional test. Please tell us if you would like to participate: Yes ☐ No ☐

Did you settle in the UK within the last 10 years?

Yes ☐ What year _____ (Please complete below questions)

No ☐

If yes, please circle if you have lived in one of the following countries?

Afghanistan	Angola	Bangladesh	Bhutan
Botswana	Cambodia	Cameroon	Central African Republic
Chad	DR Congo	Djibouti	Equitorial Guinea
Ethiopia	Gabon	Gambia	Greenland
Guinea	Guinea-Bissau	Haiti	India
Indonesia	Ivory Coast	Kenya	Kiribati
North Korea	Laos	Lesotho	Liberia
Madagascar	Malawi	Marshall Islands	Mauritania
Micronesia	Moldova	Mongolia	Mozambique
Myanmar	Namibia	Nepal	Nigeria
Pakistan	Palau	Papua New Guinea	Philippines
Sierra Leone	Somalia	South Africa	Sri Lanka
Sudan	Swaziland	Tajikistan	Timor-Leste Tuvalu
Uganda	Vietnam	Zambia	Zimbabwe

NEW PATIENT QUESTIONNAIRE

As part of the registration process, we need to find out a little about your current health and also about any history of certain sorts of illness in your family. Please answer the following questions. If you have any difficulty in completing the form, please ask for help from our reception team.

First Name:				Last Name:			
Date of Birth:			Occupation: **Email Address :**				
Do you need an interpreter?		Yes	No	Please state language:			
Your height:	Feet/inches	cm		Your weight:	Stones/lbs.	kg	
Are you currently a smoker?		Yes	No	Have you ever been a smoker?		Yes	No
If so, how many cigarettes cigars tobacco do you smoke in a day?				How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer*			
If you are a smoker and want to stop, please ask at reception.							

Is there any history in your family of any of the following illnesses?

Yes No (please circle all that apply below)

Stroke: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/Maternal grandfather

/Paternal grandmother/Paternal grandfather

Heart disease: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/

Maternal grandfather/Paternal grandmother/Paternal grandfather

Hypertension: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/

Maternal grandfather/Paternal grandmother/Paternal grandfather

Epilepsy: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/Maternal grandfather/

Paternal grandmother/Paternal grandfather

Diabetes: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/Maternal grandfather

Paternal grandmother/Paternal grandfather

Asthma: Mother/Father/Sister/Brother/Aunt/Uncle/Maternal grandmother/Maternal grandfather/

Paternal grandmother/Paternal grandfather

Please list any tablets, medicines or other treatments you are currently taking: Please list any allergies	

Do you have any of the following specific needs? Please circle **Yes / No**

☐ Sensory impairment, i.e. speech, hearing, sight ☐ Phobias, i.e. needle

☐ Mental disability ☐ Assistance/Guide dog ☐ hysical disability

☐ Uses a citizen advocate	
☐ Uses a legal advocate	
☐ Does use hearing aid	
☐ Uses sign language	
☐ Using lip-reading	
☐ Using British sign language	
☐ Uses manual note taker	
☐ Uses speech to text reporter	
☐ Uses text phone	
☐ Uses deafblind intervener	

Specific Contact Method

Patient requires Specific Contact Method	

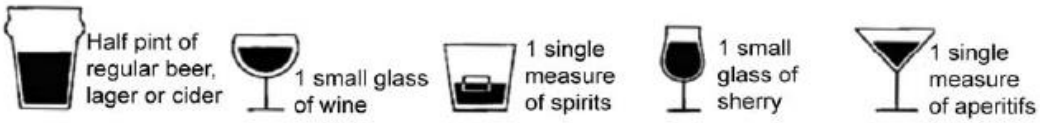
Specific Information Format

Patient requires Specific Information Format	

Information Professional

Patient requires Information Professional?	

This is one unit of alcohol...



...and each of these is more than one unit

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing 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 drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

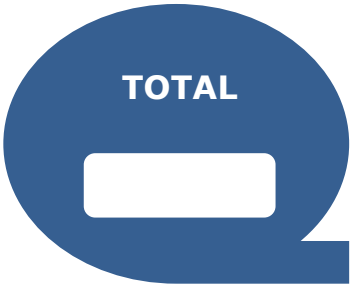
If your score is 5 or above, you must complete page 2.

Score from AUDIT- C (other side)

Remaining AUDIT questions

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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



The Royal Docks Medical Practice
21 East Ham Manor Way
London E6 5NA
Tel: 020 7511 4466

Dear Patient

The NHS in England has introduced the Summary Care Record, an electronic health record that can be accessed when you need urgent treatment from somebody other than your GP.
Summary Care Records contain key information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. You will be able to add other information too if you and your GP agree that it is a good idea to do so.

If you have an accident or fall ill, the people caring for you in places like accident and emergency departments and GP out of hours services will be better equipped to treat you if they have this information. Your Summary Care Record will be available to authorised healthcare staff whenever and wherever you need treatment in England, and they will ask your permission before they look at it.

You need to make a decision
Your GP practice is supporting Summary Care Records and as a patient you have a choice:

Yes, I would like a Summary Care Record. If you would like a summary care record please inform a member of the reception team.

No, I do not want a Summary Care Record. If you do not want a record, you need to fill in the Summary Care Record opt out form and hand it in to your GP practice. You should do this even if you have already completed a form at your previous practice.

For more information please go to the following website; http://systems.hscic.gov.uk/scr/patients
✂----------

Please return this slip to the reception at The Royal Docks Medical Practice

Emis Number: _____ **Patient Name:** _____

Date: _____ **Your Signature:** _____

Patient D/O/B: _____

Yes (to opt into Summary Care Record) ☐ No (to opt out Summary Care Record) ☐

The Royal Docks Medical Practice

Consent Form – Patient Care Text Messaging
Practice copy

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment matters.
I acknowledge that appointment matters by text are an additional service and that these may not take place on all occasions, and that the responsibility for attending appointments or cancelling them still rests with me.

The surgery does not offer a reply facility to enable a patient to respond to texts directly.

Text messages are generated using a secure facility.
I understand that they are transmitted over a public network over a public network onto a personal telephone & such as, may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advised the practice if my mobile number changes or if this is no longer in my possession. I can cancel the text message facility at any time.

Over 16s only.

Mobile Phone Number; _____

Name; _____ Date Of Birth; _____/_____/_____

Signature; _____ Date; ____/____/_____

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Please keep this copy for your information