**OAKLEY MEDICAL PRACTICE**

**New Patient Questionnaire**

**Please print in capitals. Please speak to a member of staff if you have difficulties completing this form**

Title…………. Surname ……………………………………………First Name(s) ………………………………………………………

**OAKLEY MEDICAL PRACTICE – NEW PATIENT REGISTRATION**

**We ask that you provide two forms of ID with your registration, to confirm your name, date of birth and address, though this is not essential.**

We will accept 1 form of ID from each group listed below. If no documents are available from Group 1 we will accept 2 documents from Group 2 provided they are dated within the given timeframes.

|  |
| --- |
|  **ACCEPTABLE ID DOCUMENTS - Group 1**Adoption Certificate (UK)HM Forces ID Card (UK)Passport; Current and Valid (any nationality); **Note**: expired passports will not be acceptedPhoto Identity Card; Current and Valid (EU countries only); **Note:** expired ID cards will not be acceptedUK Birth Certificate issued within 12 months of date of birthUK Driving Licence; Full or Provisional – England/Wales/Scotland/Northern Ireland/Isle of ManEither photocard with paper counterpart or old-style (pre-1998) driving licenceUK Firearms Licence**ACCEPTABLE ID DOCUMENTS - Group 2** |
| **Issued within last 12 months**  | **Issued within last 3 months**  | **Issued whenever**  |
| Bank or Building Society Document British work permit/visa Financial statement e.g. pension, endowment, ISA  | Addressed payslip Letter from a Head Teacher Mail order catalogue statement Personal correspondence or a document from a Government Department Utility bill – electricity Utility bill – gas Utility bill - telephone Utility bill – water  | Asylum Registration Card Certificate of British nationality Child benefit book Court Claim Form Court summons Credit card statement Disclosure Scotland certificate Examination certificate (e.g. GCSE, NVQ) Marriage certificate/Civil Partnership Certificate Mortgage statement National insurance number card P45/P60 statement Store card statement UK birth certificate (issued after 12 months of date of birth Valid insurance certificate Valid NHS card Valid TV licence Valid vehicle registration document |

|  |
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|  |

## Family Medical History

Has a parent or sibling suffered from Diabetes, Stroke, Cancer or Heart Disease below the age of 60 years? Yes/No

Please give more details ………………………………………………………………………………………………………………………..

## Women

Have you had a cervical smear Yes/No When was the last one? Date ……………

What was the result? …………………………………..

**Access to records**

You can view your full medical record (from the date of registration), book appointments, request medications and see your results via the NHSApp or SystmOne Online. There are certain exceptions to this eg. If there are any concerns about sensitive or potentially harmful information on your record. If you are unable to see your record you can book an appointment with a doctor to discuss this. **If you do NOT wish to have access to your full medical record please tick this box**

**Preferred Method of Contact**

**Email**

**SMS**

**Letter**

**AUDIT – C**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Scoring system** | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthlyor 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 - 8 | 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:**

**SCORE**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

**Score from AUDIT- C (other side)**

**SCORE**

**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,

**TOTAL**

 16 – 19 Higher risk, 20+ Possible dependence

**Oakley Medical Practice - Information Sharing Consent Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby give my permission for (add host organisation) to share personal information with other service providers in connection with my care, including accessing and sharing my medical, and if applicable, mental health and police records. I agree to a referral being made to (add local supportive services), in order to support my needs. I understand that (the host organisations) may hold information gathered about me from the various agencies and as such my rights under the Data Protection Act will not be affected.

**Statement of Consent:**

* I understand that personal information is held about me.
* I have had the opportunity to discuss the implications of sharing or not sharing information about me.
* **I agree that personal information about me may be shared and gathered from the following agencies:**
	+ NHS and other Health Services, including my GP practice
	+ Early Intervention Service including the police
	+ Adult Services
	+ Mental Health Services
	+ Education Support Services
	+ Social Care
	+ Voluntary Sector Organisations
	+ Housing Providers

Are there any agencies you do not want us to share or gather additional information with? Please list them here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I agree to my information being shared and gathered between services

**Your consent to share personal information is entirely voluntary and you may withdraw your consent at any time.** Should you have any questions about this process, or wish to withdraw your consent please contact: ……………………………..

**Name …………………………………………………………………..…………….**

**Address ………………………………………………………………....................**

**Post code …………………… Date of Birth …………………………..**

**Signature ……………………………………………………………….**

**Date ………………………**

**Signature of professional ……………………………………………………….**

**Print name ………………………………………………………………………….**

**Agency / service……………………………………………………………………..**