

Desborough Surgery

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Hazlemere Surgery

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www.desborough.gpsurgery.net

Desborough & Hazlemere Surgery

THIS IS A NEW PATIENT REGISTRATION FORM FOR ADULTS

- THIS FORM IS **NOT** FOR TEMPORARY REGISTRATION
- THIS FORM IS **NOT** FOR CHILDREN 0-16 YEARS OLD
- THE REGISTRATION PROCESS CAN TAKE 7-10DAYS TO COMPLETE

We will request your medical records from your previous GP, but this can take 6-8 weeks.

DO YOU TAKE REPEAT MEDICATION?

If yes, please ensure you have at least 1 months' supply of medication before submitting this registration document; the Doctor may ask to see you before authorising/issuing any repeat medication.

WRITE ONLY IN CAPITALS AND PRESENT IN PERSON AT RECEPTION WITH YOUR IDENTITY DOCUMENTS.

(please bring the original documents plus a copy for our records)

DOCUMENTS REQUIRED:

- 1. PHOTOGRAPHIC IDENTITY:** passport or driving licence
- 2. PROOF OF ADDRESS:** utility bill/council tax/bank statement
- 3. COMPLETED GMS1 FORM**

Patient information leaflets, forms and OPT-OUT details can be found at:

WWW.DESBOROUGH.GPSURGERY.NET/PATIENT-INFO/NEW-PATIENT-REGISTRATION

Data sharing consent choices....

By submitting this registration form, you indicate your consent to opting-in for these services. If you do not want to receive the service(s) use the opt-out forms indicated and return to reception.

1. NHS England has introduced the **Summary Care Record (SCR)**, which will be used in emergency care. The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare professionals providing care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about you.

1a You can choose to share an **‘additional’** Summary Care Record which contains additional information such as: significant medical history, reasons for medication, anticipatory care (such as management plan for long term conditions and end of life care information) and immunisations.

I expressly request to share my “additional” Summary Care Record. Signed: _____

If you wish to **OPT OUT** of SCR, please complete an SCR Opt-Out form available on our website.

2. Bucks have a new approach to sharing patient records between clinicians and other professionals who may provide your care. **My Care Record (MCR)** is a system that allows medical and social care professionals to access your GP records so they can make the right choices about the care and medical attention you need.

If you wish to **OPT OUT** of MCR please submit an MCR Opt-Out form available on our website

- 3. Your mobile number and email address may be used by the Surgery to contact you.
 - o **SMS Text** - to send you reminders for appointments, vaccination reminders, annual health checks, surgery closures etc.
 - o **Email** - to send you personal letters, surgery newsletters and occasional questionnaires.

Helpful patient information leaflets and opt-out forms can be found at:
www.desborough.gpsurgery.net/patient-info/new-patient-registration

The information we collection about you and how we use it can be found on our website: <https://desborough.gpsurgery.net/gdpr>

I confirm that the information I have provided is true to the best of my knowledge.

Signature

Date:

Signature of patient Signature on behalf of patient

Continue to Lifestyle questions and complete all sections.

Checklist before coming in to the surgery;

- 1. Have you completed and SIGNED all relevant sections?
- 2. Have you completed the GMS1 registration form?
- 3. Do you have 2 different forms of identification and a copy or your passport?

Lifestyle - Please tell us about yourself:

Are you a Carer for someone else?
(Either as a paid job or unpaid for a relative etc.)

Yes (918A) No

If yes, please tell us who or the name of the Organisation for whom you work for.

Do you have a carer?

Yes (918F) No

If **yes**, please tell us the name, address & contact details of your Carer:

Are you happy for us to contact your carer about you? Yes No

I give permission for my Carer to have access to my medical records held by the Practice

Signed: _____

Date: _____

Female patients only

Are you currently, or think you may be pregnant? Yes No

Lifestyle measurements

Please enter your height & weight:

Height: _____	Weight: _____
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Lifestyle smoking

Do you **currently smoke**: Yes No
If yes, do you smoke: Cigarettes Cigars Pipe

How many cigarettes/cigars do you smoke a day: <1/day 1-9/day 10-19/day 20-39/day 40+/day

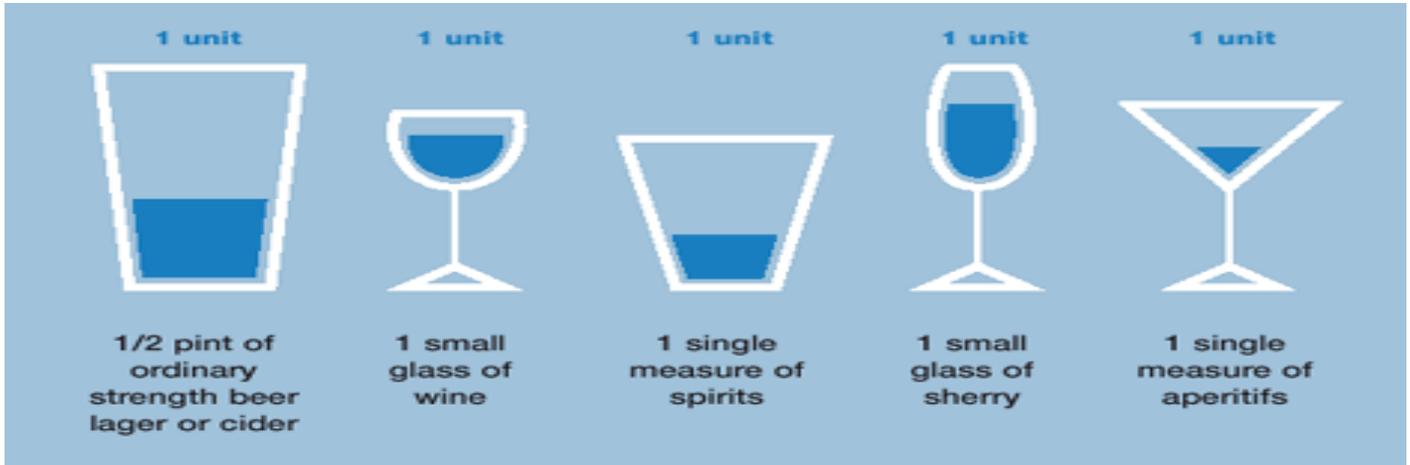
Are you an **ex-smoker**? No Yes - When did you give up?

Lifestyle alcohol

Please complete if 16 years or over;

Do you drink alcohol: No Yes If yes answer the following questions;

This is one unit of alcohol...



AUDIT – C – part 1

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	<input type="text"/>
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+	<input type="text"/>
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	<input type="text"/>

Scoring:

A total of 5 or more indicates possible increasing or higher risk drinking. An overall total score of 5 or above is **AUDIT-C** positive.



Continue to Part 2 on the next page, only if your score is 5 or more

Only complete this section if you scored 5 or more in part 1 of AUDIT-C

Part 2 - Remaining AUDIT-C 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	<input type="text"/>
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	<input type="text"/>
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	<input type="text"/>
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	<input type="text"/>
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	<input type="text"/>
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	<input type="text"/>
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	<input type="text"/>

Score for Part 2 equals total of above question:

Your total Audit Score (part 1+ part 2) = _____

- 0 -7 indicates sensible or lower risk drinking
- 8-15 indicates increasing risk drinking
- 16-19 indicates higher risk drinking
- 20 and over indicates possible alcohol dependence



Please make an appointment with our practice nurse if your score is 8 or more.