**REGISTRATION FORM 2018 – UNIVERSITY MEDICAL CENTRE**

**Please complete in FULL using BLOCK CAPITALS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:** | | | | **Male □ Female □ Transgender □** | | | | |
| **Surname:** | | | | **Town and Country of Birth:** | | | | |
| **Forename:** | | | | **Date of Birth:** | | | **Age:** | |
| **Address in Bath (including post code):** | | | | **University Department** | | | | |
| **Length of Course** | | | | |
| **Mobile Number: …………………………………………………**  **Please be aware that you may occasionally receive communications from us by text message. Normally these will be reminders about your booked appointment or medical reviews.**  **If you DO NOT wish to receive text message reminders from the University Medical Centre please tick here** □ | | | | **Contact in case of an Emergency**  **Title: Forename: Surname:**  **Home Tel No:**  **Mobile Tel No:**  **Relationship to patient:**  **Is this your next of kin? Yes** □ **No** □  (*closest relative)* | | | | |
| **Email Address:** | | | | | | | | |
| **Do you suffer from any of the following (answer YES or NO):** | | | | | | | | |
| Asthma (needing inhalers in the last year) | |  | | Stroke/Mini Stroke | | | |  |
| Diabetes – Type I | |  | | Atrial Fibrillation | | | |  |
| Diabetes – Type II | |  | | Cancer | | | |  |
| Epilepsy | |  | | Obesity | | | |  |
| Depression Needing Treatment | |  | | Raised Blood Pressure Needing Treatment | | | |  |
| Serious Mental Health Problems eg eating disorder  If YES, please specify: | |  | | Heart Disease | | | |  |
| Under–Active Thyroid (hypothyroidism) | |  | | Kidney Disease | | | |  |
| **Do you have any other medical problems not listed above?** If YES, please list: | | | | | | | | |
| **Are you currently taking any medication?** If YES,please list: | | | | | | | | |
| **Have you been vaccinated against:** | | | | | | | | |
| MMR (Measles, Mumps, Rubella) :  Meningitis ACWY : | **Yes □ No** □  **Yes □ No □** | | | | Date 1st MMR:  Date: | Date 2nd MMR: | | |
| **If you are female and over 25, have you had a smear test? Yes** □ **Date:……………………………………………. No** □ | | | | | | | | |
| **Are you allergic to any medications?** | | | **Do you have any other allergies? eg hayfever, animals** | | | | | |
| **Do you smoke?** Never □ Ex-Smoker □ Current Smoker □  **If Current Smoker :** Leaflet/Information given □ | | | | | | | | |
| **Are you registered disabled?**  Yes □ No □ | | | **Are you a carer for anyone?**  Yes □ No □ | | | | | |
| **Would you like to access your records and make appointments on-line using Patient Access?**  YES □ (please complete last page) NO □ | | | | | | | | |
| **Office Use Only: Photo ID presented:**  **Second form of ID:** □ …………………………..  Driving Licence □  EU Identity Card □ **Witnessed and authorised by UMC staff:** Initial here ……………..  Passport □  British Resident Permit □ | | | | | | | | |

**AUDIT-C Questionnaire**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. How often do you have a drink containing alcohol?

□ a. Never

□ b. Monthly or Less

□ c. 2-4 times a month

□ d. 2-3 times a week

□ e. 4 or more times a week

1. How many standard drinks containing alcohol do you have on a typical day?

□ a. 1 or 2

□ b. 3 or 4

□ c. 5 or 6

□ d. 7 to 9

□ e. 10 or more

1. How often do you have six or more drinks on one occasion?

□ a. Never

□ b. Less than monthly

□ c. Monthly

□ d. Weekly

□ e. Daily or almost daily

For Office Use Only: Score: Initials: .

**ETHNICITY AND FIRST LANGUAGE**

**Why is it important to fill out ethnicity and first language?**

*The Government is committed to reducing health inequalities: ensuring that whatever their economic or ethnic background patients receive the highest possible quality of care. Accurate information is required in order to ensure that the services fulfil this obligation.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ETHNIC GROUP** | Tick  Here |  | **MAIN LANGUAGE SPOKEN** | |
| **Decline**  Declined: patient chooses not to supply this information |  | **Decline**  Declined: patient chooses not to supply this information | Tick |
| **A: White**   * British |  | (Please circle your first language spoken)  A Arabic  Bengali  Bulgarian  Cantonese  Danish  Dutch  English  French  Gaelic  German  Greek  Gujarati  Hakka  Hindi  Japanese  Italian  Korean  Mandarin  Norwegian  Patois/Creole  Polish  Portuguese  Punjabi  Russian  Somali  Spanish  Swedish  Tamil  Thai  Turkish  Urdu  Vietnamese  Welsh  British Sign Language  Any other language (specify) | |
| * Irish |  |
| * Any other White background   (please write in line below) |  |
| **B: Mixed**   * White and Black Caribbean |  |
| * White and Black African |  |
| * White and Asian |  |
| * Any other mixed background   (please write in line below) |  |
| **C: Asian or Asian British**   * Indian |  |
| * Pakistani |  |
| * Bangladeshi |  |
| * Any other Asian background   (please write in line below) |  |
| **D: Black or Black British**   * Caribbean |  |
| * African |  |
| Any other black background  (please write in line below) |  |
| **E: Chinese or other ethnic group**   * Chinese |  |
| * Any other   (please write in line below) |  |

**UNIVERSITY MEDICAL CENTRE**

We offer our patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

**What is the NHS Summary Care Record?**

The Summary Care Record contains basic information about:

* **any allergies you may have**
* **any unexpected reactions to medications**
* **any prescriptions you have recently received**

The intention is to help clinicians in A & E Departments and ‘Out of Hours’ health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

**Children under the age of 16**

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you are happy for a Summary Care Record to be set up for you then you need take no further action. If you want to opt-out now please fill in your details below and return the form to Reception as soon as possible.

**ONLY COMPLETE THE SECTION BELOW IF YOU**

**DO NOT WANT A SUMMARY CARE RECORD**

**NAME: DATE OF BIRTH:**

**NO I do not want a Summary Care Record** 🞎 (please tick)

**Signed ………………………………………………… Date ……………………………………**

For more information visit [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk) or if you cannot find the answers to your questionscall 0300 123 3020.

**UNIVERSITY MEDICAL CENTRE**

**Patient Online: Registration for Access to GP online services**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Date of birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | Usual GP |  |
| Telephone |  | | |

*I wish to have access to the following online services (tick all that apply*)

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my medical record – Medication and allergies | 🞏 |
| 1. Accessing my medical record – Test results and immunisations | 🞏 |
| 1. Accessing my medical record – problems, consultations | 🞏 |

**Application for online access to my medical record**

*I wish to access my medical record online and understand and agree with each statement (please tick)*

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice immediately via Secure Messaging within my Patient Access account or I will contact the practice by telephone after 2pm | 🞏 |
| 1. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**For practice use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Method  Vouching   Vouching with information in record   Photo ID and proof of residence   Documents used: 1.  2. | |
| Identity verified by Receptionist: | Date: | |
| Authorised by GP | | | | Date |
| Date account created: | | | | Coded: Xabui |
| Date passphrase sent: | | | |  |
| Level of record access enabled  All   Prospective  Retrospective   Detailed coded record   Limited parts  | | Notes / explanation | | |