Cathedral Medical Group

Health Information Form
From January 2023 onwards

To be completed by all people who wish to register

PLEASE NOTE: We require ONE form of photographic identification to register with the practice

*You may either print and complete this form **LEGIBLY IN CAPITAL LETTERS** or you can fill it out using your computer and then print it. Use the tab key to move between fields. Please answer all questions if possible.*

Title: ______________________

NHS No: ☐☐☐☐☐☐☐☐☐☐

Surname Name: ______________________

First Names(s): ______________________

Middle Name: ______________________

Other Name(s) (Maiden/previous): ______________________

Preferred Name(s): ______________________

Biological Gender: ☐ Male ☐ Female

Preferred Pronouns: ______________________

Date of Birth: ____ / ____ / ____

Place of Birth: Town: ______________________

Country: ______________________

Current Address: ______________________

Postcode: ______________________

Telephone No.: ______________________

Mobile No: ______________________

What is your FIRST language? ______________________

Do you need a translator? ☐ *Yes* ☐ *No*

Occupation: ______________________

Ethnicity: ☐ British ☐ Irish ☐ Asian ☐ Caribbean ☐ African ☐ Indian ☐ Pakistani ☐ Chinese ☐ Bangladeshi ☐ Other White ☐ Other Black ☐ Other Mixed ☐ Other

General Data Protection Regulations

I give permission for messages to be left on my answer phone: ☐ *Yes* ☐ *No*

*If you have supplied a mobile number you may receive text messages for appointment reminders, access to on line services, vaccination invites, annual reviews, some blood test results i.**e for direct patient care related activities only.** Please tick here to consent to receive these text messages Yes* ☐

If you do not wish to receive these text messages tick here No ☐ *(please note, no means no – so no text if we need to change something at short notice, or if you want a blood test result etc)*

We would like to contact you periodically by sms or email to ask you about services and developments at the practice. If you want to be involved in this, please tick here and supply your email address. ☐ *We don't use your email for direct patient care. (**unless you have given it to us for administraton purposes for on-line access**) You can change your mind at anytime, just let us know.*
Email Address (Only if you have ticked above): ______________________

If you are registering a child (under 16), please state who has parental responsibility for the child.

Name: ______________________ Relationship: ______________________

Please help us to trace your previous medical records by providing the following information:

Previous Address: ______________________

Postcode: ______________________

Previous GP: ______________________

Address of previous GP: ______________________

If you are from abroad, please provide the following details:

Your first UK address where registered with a GP ______________________

____

If previously resident in UK, date of leaving: ______________ Date you first came to UK: ______________

If you are returning from the Armed Forces, please provide the following details:

Address before enlisting ______________________

____

Service or personnel no: ______________ Enlistment date: ______________

Next of Kin - In Case of Emergency:

Please provide us with the details of a person we may contact in case of an emergency:

Name: ______________________ Relationship to you: ______________

Address ______________________

____

Tel Numbers: ______________________

Please note: Should your contact not answer the phone we will only leave a message that says to contact our surgery urgently regarding yourself. Its is your responsibility to keep this information updated.

Carer Support Services

Do you have a carer? ☐ Yes ☐ No If Yes, and they are not your Next of Kin, please provide a name and contact number in case of emergency: ______________________

Are you a carer? ☐ Yes ☐ No

If you are looking after someone who could not manage without your help, you are a carer.

Details of the person you care for:

Name: ______________ Date of birth: ______________

Address: ______________________

____

____

Mobile No: ______________ Home No: ______________

GP Details: ______________________

☐ Please pass my details to the Carer Support West Sussex

☐ Please refer me to Adult Care Services for a Carer's Needs Assessment

Please let us know if you have any information or communication needs and how we can meet those needs

……..

Please let us know your preferred communication method………………………………………………………

(If you have a long term condition and we need to invite you for reviews, we tend to write to you as we need to give you more information than can be put on a text message. However, second invites can be sent by text.)

About You

Height :	______ Metres	or	______ Feet	______ Inches
Weight:	______ Kg	or	______ Stones	______ Pounds

Do you take regular exercise? ☐ Yes ☐ No

If so, list regular activity:

Do you have any allergies? (e.g. drugs, foods, etc…) ☐ Yes ☐ No

If so, please list here: ____

Do you smoke? ☐ Never Smoked ☐ Ex-Smoker approx quit date……….. ☐ Smoker

Smoking is detrimental to your health. Smoking cessation advice and support is available here please ask.

Have you suffered from any of the following conditions?

Condition	Details	Date of onset/diagnosis (if unknown, estimate year)
☐ Asthma	☐ Currrent (using inhaler/medication now)	/ /
	☐ Past / Childhood (not using inhaler/medication now)	/ /
☐ Diabetes	☐ Insulin dependent	/ /
	☐ Non-insulin dependent	/ /
☐ Epilepsy	Date of last fit: / /	/ /
☐ Tuberculosis		/ /
☐ Eating Disorders		/ /
☐ Mental Illness	☐ Serious (e.g. Bi-polar disorder, Schizophrenia)	/ /
	☐ Common (e.g. anxiety, depression)	/ /

Please add any additional information that may be relevant. This might include a serious illness you have suffered or operations you have had. Where relevant, please include dates.

Additional information to be completed by woman only

Have you had a cervical smear test? ☐ Yes ☐ No

If so, where/who took it? ☐ GP ☐ Private ☐ Family Planning Clinic ☐ Abroad

Result: ☐ Normal ☐ Abnormal Date: / / Next due: / /

Please complete the following questionnaire if you are 16 or over:

Do you drink Alcohol? ☐ Yes ☐ No

If so, on average how many units per week do you drink? Units

(One unit is equivalent to half a pint of beer, one glass of wine or a pub measure of spirits)

Questions: (Audit C)	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 standard alcoholic drinks do you have on a typical day when you are drinking? *	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

A total scoring of 5+ indicated harmful drinking. You will be sent a further questionnaire for completion

Please identify your chosen preferred pharmacy for your prescriptions to be sent to:

____

Digital Services

Online Repeat Prescription Requests

☐ Yes - I would like to register for online repeat prescription requests

☐ No - I am not interested in registering for online services

In order to process online access we need either a mobile phone number of a personal email address, so we may set up a user log in and password (that you will be asked to change on first log in) This information can be sent to you via mobile or email, IF WE HAVE THESE ON RECORD and verified.

☐ Yes you may use my email address for on line access administration –

Email address if not supplied earlier ………………………………………..

Without one of these, you will need to come back to the Practice to pick up a paper copy of the log in details and should you need any resetting of passwords or admin processes - you will need to return to the practice to collect paper print outs.

Access to your Medical Record

There are several options available for key clinical staff who are not Cathedral Medical Group staff, with your agreement, to access your medical records, Summary Care Record, and the Enriched Summary Care Record are two ways.

Summary Care Record

The NHS in England is introducing the Summary Care Record, which will be used in emergency care. The record will contain information about any medicines you are taking, allergies you suffer from and any bad 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 staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health. Your GP practice is supporting Summary Care Records and as a patient you have a choice.

	Yes	No	Signature
Are you happy to have a Summary Care Record?			

Additional Information - Enriched Summary Care Record

The NHS in England is introducing additional information onto your Summary Care Record. What sort of detail will be added? It means that long term health conditions such as asthma, diabetes, heart problems will be shown. Relevant medical history - including clinical procedures you may have had. Your health preferences – for example special dietary needs. Your personal preferences such as religious beliefs or legal decisions you have made. Finally, your immunisations record, such as tetanus or routine childhood vaccinations

Please note - **specific sensitive information** - such as fertility treatment, sexually transmitted infections, pregnancy terminations or gender reassignment **WILL NOT be included** - unless you specifically ask for these to be included.

Your GP practice is supporting the "Additional information Summary Care Records and as a patient you have a choice. If you wish to have further information, please ask reception for the "NHS Summary Care Record – Additional Information Leaflet"

	Yes	No	Signature
Are you happy to have an Enriched Summary Care Record?			

Shared service access to medical records. You may be under the care of other primary, secondary and community care health services. These service providers will always ask you for consent to access your medical records if they are caring for you.

Signature	Date

I have read the above. I confirm the information I have provided is a full and correct record of my medical history.

Signed: ______________________ Date: ____/____/________

FOR OFFICE USE ONLY

Supplementary Question seen by patient ☐*Yes* ☐ *No* *Self declaration completed* ☐*Yes* ☐ *No*

If self declaration completed S1 received ☐*Yes* ☐ *No or EHIC or PRC1 ticked* ☐*Yes* ☐ *No*

Office use only Code as: Xaasn

Patient NOK record on S1 groups and relationships ☐*Yes* ☐ *No*

GDPR

Patient consented to leave messages on answer phone ☐*Yes* ☐ *No - read coded Yes* ☐

On Reminders S1 Yes ☐

DIGITAL

Patient consented to SMS messaging, appt reminders, vaccinations invites etc - direct patient care

☐*Yes* ☐ *No - read coded - Updated on S1 dissent recorded SMS* ☐*Yes*

Patient consented to email for surveys, new services, PPG info etc - non direct patient care ☐*Yes* ☐ *No*

Patient consented to on line access ☐*Yes* ☐ *No - read coded, email added on S1* ☐*Yes*

Patient on line access set up by mobile phone / email ☐*Yes* ☐ *No*

On line services set up patient sent text/email with log in and password details ☐ *Yes* ☐ *No*