REGISTRATION DOCUMENTS

This document contains the forms you will need to register with us.

Please bring photo ID – either passport or driving licence AND two recent utility bills as proof of address.

LIGHTHOUSE MEDICAL PRACTICE
www.lighthousepractice.co.uk

MILFOIL DRIVE
EASTBOURNE, BN23 8BR
Tel: 01323 766358

6 COLLEGE ROAD
EASTBOURNE BN21 4HY
Tel: 01323 735044

NEW PATIENT QUESTIONNAIRE — CONFIDENTIAL

Please ensure that you complete this questionnaire as fully and accurately as you can, as it is important to have the correct information on your medical records.

Surname:	**Forenames:**	
Address: **Postcode:** **Are you happy for the Practice to leave non clinical messages on your answer machine?** **YES/NO** **Are you a Carer or do you have a Carer?** **YES/NO** **Name of person you care for:**	**Date of Birth:**	
	Home Telephone:	
	Mobile Telephone:	
	Work Telephone:	
	Email Address:	

ETHNICITY: *Please tick relevant box*			
White		Pakistani	
Black African		Bangladeshi	
Black Caribbean		Asian	
Indian		Other *	
** Other: Please specify*			
FIRST LANGUAGE:			

IMMUNISATIONS: *Please tick if you know you have had each one and the date, if known*		
Vaccine:	**Y/N**	**Date**
Diphtheria/Tetanus/Whooping Cough		
Diphtheria/Tetanus		
Measles / MMR		
Meningitis		
Hib		
BCG		
Rubella		
Polio (in last 10 years)		
Tetanus (in last 10 years)		
Influenza		
Pneumococcal		

MEDICAL HISTORY: *Please tick if you have every had any of these and given brief details (including dates) below*			
Asthma		COPD	
Thyroid		Depression	
Stroke		Diabetes	
Hypertension (high blood pressure)		Heart Attack or Angina	
Details:			

FAMILY HISTORY: *Please tick if any blood relatives (eg, parents, siblings, grandparents or children) have had any of the following and please give details of which relative below*			
Hypertension		Diabetes	
Heart Disease over age 60		Heart Disease under age 60	
Asthma		COPD	
Stroke		Eczema	
Cancer – breast		Depression	
Cancer – bowel		Thyroid Problems	
Cancer – other		Hay Fever	
Details of relative:			

PERSONAL HEALTH: *Please tick relevant boxes*			
Smoker		Number per day	
Past Smoker		Year gave up	
Never smoked			
Alcohol **		Units per week	
Please see questionnaire overleaf. ** ALCOHOL QUESTIONNAIRE COMPLETED Y/N			

DIET: *Please indicate which applies to you*	
Mixed Diet	Vegetarian Diet
Vegan Diet	Other – please state

EXERCISE: *Please indicate which applies to you*			
No exercise		Light exercise	
Moderate exercise		Heavy exercise	
CURRENT OCCUPATION:			
SELF:		PARTNER:	

***SOCIAL CIRCUMSTANCES**:* *Please tick relevant box*			
Single		Separated	
Married		Widowed	
Divorced		Co-habiting	
Civil Partnership			

NUMBER OF CHILDREN: *Please indicate how many*			
Male		Female	
SCHOOL ATTENDED			
HOUSING: *Please tick relevant box*			
Privately owned		Housing Assoc'n	
Privately rented		Council	

MEDICATION: *Please list any current medication:*

ALLERGIES*:* *Please list any allergies to drugs, dressings, food or other substances and give details of what happens*

WOMEN ONLY:	
Last Cervical Smear Test:	
Year:	
Result:	
Was it done at your previous GP?	Yes / No

OBSTETRIC HISTORY: *Please record the dates of any pregnancies, including any complications or miscarriages*

Please sign below and return the completed form to the Surgery.	
Signature:	Date:

ALCOHOL SCREENING QUESTIONNAIRE:		**SCORE**				
		0	**1**	**2**	**3**	**4**
1.	How often do you have a drink containing alcohol?	Never	Less than monthly	2-4 times a month	2-3 times a week	4 or more times a week
2.	How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
3.	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
If the total score is five or above it might be useful to discuss alcohol consumption further						

	Word of mouth	Passing by	Website www.lighthousepractice.co.uk	Other (please specify)
How did you hear about our Practice?				

NHS Family doctor services registration *GMS1*

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date_____/_____/_____

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation **Date** _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date** _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Your emergency care summary

Summary Care Record – your emergency care summary

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, healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information, telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no Date .....

Ref: 4705

PLEASE LOOK!

The Lighthouse Medical Practice would like to inform you of the services that we offer:

- We have a Practice news letter available, please ask at reception for a letter

- We have a range of extended hours available. We are open on a Monday evening at alternate sites at College Road and Ian Gow Surgery, with Doctors and Nurses appointments available.
  We are also open on a Saturday morning at alternate sites.

- We have a practice website address, please have a look at our website www.lighthousepractice.co.uk

- You can now order your prescriptions on line, please enquire at the reception desk.

- We have an automated telephone system that can offer a wide range of pre-bookable appointments. Please ask at reception if you have any questions about the telephone system. The automated system comes on at 6am in the morning and can offer a range of pre-bookable appointments.

Lighthouse Medical Practice

Patient Consent

Name: _____ **Date Of Birth:** _____

We want to be able to contact you in the easiest and most efficient way possible. This could be on the phone, via text or email. Being able to do things this way saves time for you and us.

This is to confirm that I give my permission for information/messages regarding medical and/or administrative matters to be: *(Please tick boxes as applicable)*

1. **LEFT ON MY ANSWERPHONE BOTH ON MY LAND LINE AND/OR MOBILE TELEPHONE** ☐
2. **SEND TO ME VIA TEXT MESSAGES TO THE TELEPHONE NUMBER BELOW** ☐
3. **SEND VIA EMAIL TO THE ADDRESS GIVEN BELOW** ☐
4. **LEFT WITH THE FOLLOWING PEOPLE** ☐

Name: _____ Relationship: _____ Tel:_____

Name: _____ Relationship: _____ Tel:_____

Is there anything we need to know about you in order to help us communication with you e.g. hearing impairment?

……..

……..

Is there something that we can do practically to help us communicate with you better e.g. Form or method of communication, or print size?

……..

……..

Do you need anyone to help you communicate with us e.g. interpreter or advocate?

……..

……..

IN ORDER TO MAINTAIN OUR RECORDS, PLEASE CAN YOU ALSO CONFIRM THE FOLLOWING:

Emergency Contact Number:_____ Email Address:_____

Mobile telephone number:_____ Landline telephone number:_____

Signed: _____ **Date:**_____