THE ADAM PRACTICE

| **COMMUNICATION NEEDS:** | | | | |
|---|---|---|---|---|
| Do You have any special Communication Needs? | | | ☐ Yes | ☐ No |
| If 'Yes' | ☐ Sign Language | ☐ Large Print | ☐ Other:…………………………………… | |
| **Accessible Information**: If you have stated that you have any special communication needs on this form we will do our best to accommodate your needs. Should your needs change please inform us. | | | | |

| **PERSONAL DETAILS:** | | | | |
|---|---|---|---|---|
| Title: | | | | |
| Surname: | | | | |
| Given Name: | | | | |
| Middle Name(s): | | | | |
| Known As: | | | | |
| Previous Surname (where applicable): | | | | |
| Date of Birth: | | | | |
| NHS Number: | | | | |
| Gender: | ☐ Male | ☐ Female | | |
| Town+Country of Birth: | | | | |
| Marital Status: | | | | |
| Ethnicity: | ☐ British<br>☐ Chinese<br>☐ Other Asian<br>☐ Pakistani | ☐ African<br>☐ Indian<br>☐ Other Black<br>☐ W&B African | ☐ Bangladeshi<br>☐ Irish<br>☐ Other Mixed<br>☐ W&B Caribbean | ☐ Caribbean<br>☐ Other White<br>☐ White Asian<br>☐ Refuse to Divulge |
| Main Language: | | | | |
| Interpreter Required? | ☐ Yes | ☐ No | | |

| **HOME ADDRESS:** | |
|---|---|
| House Name\Flat No.: | |
| Street: | |
| Locality: | |
| Town: | |
| Postcode: | |

| **CONTACT DETAILS:** | | | |
|---|---|---|---|
| Home Telephone: | | **Consent to leave voice messages?** | **Y / N** |
| Work Telephone: | | **Consent to leave voice messages?** | **Y / N** |
| Mobile Telephone: | | **Consent to leave voice & SMS messages?** | **Y / N** |
| Email Address: | | | |
| The Adam Practice may wish to contact you via **email** regarding your results, appointments or other medical related issues. Do you give your consent to the practice to contact you via email containing confidential information?<br>☐ Yes ☐ No | | | |

| **PATIENT CONTACTS:** | |
|---|---|
| Next of Kin: | |
| Relationship: | |
| Telephone Number: | |

| **PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:** | |
|---|---|
| Previous address in the UK: | |
| Name & Address of last GP: | |
| Where were you last treated? : | (e.g. GP surgery, walk-in centre, A&E etc) |

## IF YOU ARE FROM ABROAD: (PLEASE COMPLETE APPENDIX 1 - 'PATIENT DECLARATION')

| First UK address where registered with a GP: | |
|---|---|
| If previously resident in UK date of leaving: | |
| Date you first came to live in the UK: | |

## IF YOU ARE RETURNING FROM THE ARMED FORCES:

| Address before enlisting: | | | |
|---|---|---|---|
| Service or Personnel No.: | | | |
| Enlistment Date: | | Date of Leaving: | |

## CARERS:

| | | |
|---|---|---|
| Are you a Carer? | ☐ YES | ☐ NO |
| If YES, would you like to be added to the Practice's register to receive regular information and meeting dates | ☐ YES | ☐ NO |

(If yes) I care for (name):

Relationship to you:

| The person I care for has: | ☐ Dementia | ☐ Physical Disability | ☐ Mental Illness | ☐ Chronic Disease |
|---|---|---|---|---|

## MEDICAL HISTORY:

Please tick all current or past illnesses/operations including dates where possible:

| | | |
|---|---|---|
| ☐ Heart Disease / Angina | ☐ Diabetes | ☐ Epilepsy |
| ☐ High Blood Pressure | ☐ Stroke/TIA | ☐ COPD |
| ☐ Asthma | ☐ Cancer | ☐ Hypothyroidism |
| ☐ Osteoporosis | ☐ Rheumatoid Arthritis | ☐ Dementia |
| ☐ High Cholesterol | ☐ Other (please state): | |

**Do you have any Allergies?** ☐ YES - Please state: ☐ NO
(e.g. antibiotics, food, bee sting, latex)

**Immunisations:** If known, please circle the immunisation received and complete the date:

| Vaccine | Date Received | Vaccine | Date Received |
|---|---|---|---|
| ☐ Pneumococcal | | ☐ Polio | |
| ☐ Tetanus | | ☐ Yellow Fever | |
| ☐ Typhoid | | ☐ Hepatitis B | |
| ☐ Hepatitis A | | ☐ MMR | |

**LADIES:** Are you currently Pregnant? ☐ YES ☐ NO

If you are pregnant please provide estimated delivery date:

## HEALTH INFORMATION:

| Weight: (st\lbs or Kgs) | | Height: (ft\" or metres) | |
|---|---|---|---|

**Smoking Status**: (please tick one box only)

☐ I am a Smoker

**(For help to stop smoking phone 0800 007 6653 or visit ww.nhs.uk/smokefree)**

☐ I have never smoked ☐ I am an ex-smoker - Date quit:

**Drinking:**
Number of Alcohol units consumed per week;

Please complete the following questions:
**(Alcohol 'FAST' screening test)** **Screening test declined** ☐

| Scoring: | 0 | 1 | 2 | 3 | 4 | Total |
|---|---|---|---|---|---|---|
| How often do you have 8 (Men) or 6 (Women) or more drinks one occasion? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily | |

Only answer the following 3 questions on the next page if your score above is 2,3 or 4:

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| Scoring: | 0 | 1 | 2 | 3 | 4 | Total |
|---|---|---|---|---|---|---|
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily | |
| Has a relative/friend/clinician been concerned about your drinking/advised you to cut down? | Never | Less than Monthly | Monthly | Weekly | Daily or almost daily | |
| | | | | | **Total** | |

## CURRENT MEDICATION:

**If you have a repeat medication slip from your previous GP please attach to this form.**

**Electronic Prescription Service:**
The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your new preferred pharmacy:

## PRACTICE SERVICES / PATIENT GROUPS:

| | | |
|---|---|---|
| Would you be interested in joining our **Patient Participation Group (PPG)**? | ☐ YES | ☐ NO |
| Do you wish to register for the **SystmOnline** service? (Online prescriptions, appointment booking, view summary care record) | ☐ YES | ☐ NO |

## OTHER INFORMATION / PATIENT CONFIRMATION:

**Declaration:** In accordance with the General Data Protection Regulation (GDPR), the Practice needs consent from any Patient for us to contact them regarding their medical treatment via the means you have detailed in this form. By providing the information on this form you are consenting to be contacted about your medical needs by the practice. Also by completing and signing this form you are agreeing to abide by the details in the Adam Practice Patient Contract and Zero Tolerance Policy (copies of which can be found on the practice website or requested from Reception). **If any of the details on this form change in the future please inform us.**

| Signed: | Date: |
|---|---|

**Should you require any further information about the Practice please refer to the Practice Website: www.adampractice.co.uk or speak to Reception.**

## DATA SHARING – YOUR CONSENT AND CHOICES:

Please read the accompanying leaflet which details 'How we use your Health Record'.
To **OPT-OUT**, please ask a member of staff.

## NHS DONOR REGISTRATION:

I wish to register my details on the NHS Organ donor &\or the NHs Blood Donor register(s) as someone whose organs/tissue may be used for transplantation after my death &\or someone who may be contacted and would be prepared to give blood.
For more information visit www.uktransplant.org.uk

**I would like to donate: (Please tick all boxes that apply)**

| | | |
|---|---|---|
| ☐ Any of my organs & tissue **or:** | ☐ Any part of my body **or:** | |
| ☐ Heart only | ☐ Liver only | ☐ Corneas only |
| ☐ Kidneys only | ☐ Lungs only | ☐ Pancreas only |

| | | |
|---|---|---|
| I would like to join the Blood donor register: | ☐ Yes | ☐ No |
| I have given Blood in the last 3 years: | ☐ Yes | ☐ No |
| **Signature** confirming consent/agreement of items ticked above: | | |

## RECEPTION ONLY:

| | | | | | |
|---|---|---|---|---|---|
| Type of ID Seen: | 1. | | 2. | | |
| GP Allocated: | ☐ YES | ☐ NO | Patient informed: | ☐ YES | ☐ NO |
| Actions completed & ID Seen by (initials): | | | | | |

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## Appendix 1

# PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

## 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

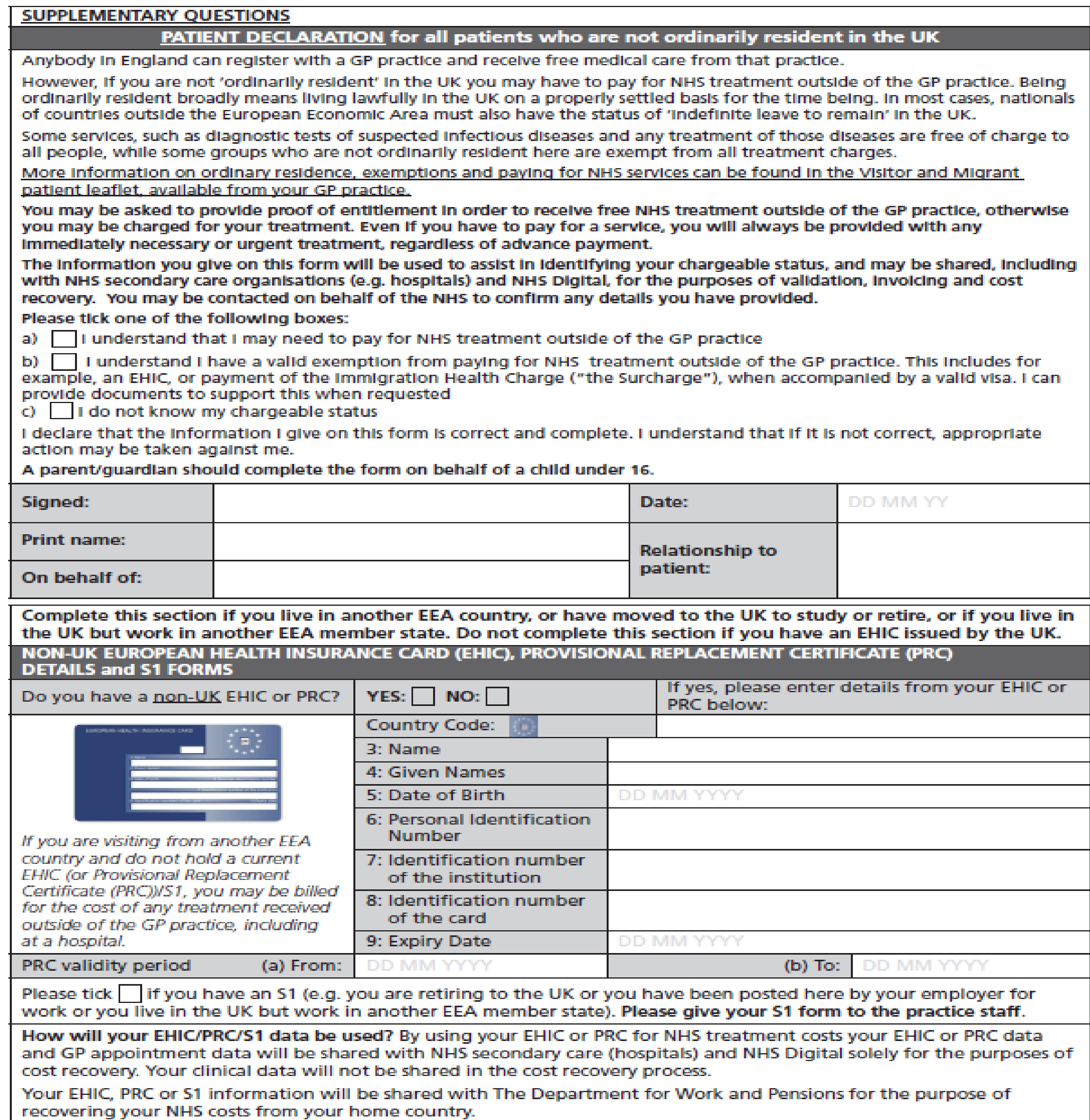
☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number



**SUPPLEMENTARY QUESTIONS**

**PATIENT DECLARATION for all patients who are not ordinarily resident in the UK**

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.**

**The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.**

**Please tick one of the following boxes:**

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

**A parent/guardian should complete the form on behalf of a child under 16.**

| **Signed:** | | **Date:** | DD MM YY |
|---|---|---|---|
| **Print name:** | | **Relationship to patient:** | |
| **On behalf of:** | | | |

**Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.**

**NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS**

| Do you have a non-UK EHIC or PRC? | YES: ☐ NO: ☐ | If yes, please enter details from your EHIC or PRC below: |
|---|---|---|
| | Country Code: | |
| | 3: Name | |
| | 4: Given Names | |
| | 5: Date of Birth | DD MM YYYY |
| | 6: Personal Identification Number | |
| | 7: Identification number of the institution | |
| | 8: Identification number of the card | |
| *If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.* | 9: Expiry Date | DD MM YYYY |
| PRC validity period (a) From: | DD MM YYYY | (b) To: DD MM YYYY |

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

**How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

**Send this form to:** NHSDigital-EHIC@nhs.net