Southgates Medical & Surgical Centre

41 Goodwins Road
King's Lynn, PE30 5QX
Tel: Appointments 01553 819477
Surgical Unit/Admin 01553 819460
www.southgates.org.uk

PROOF OF IDENTITY

Dear Patient

We are now asking all patients who wish to be registered with us for proof of identity. This is mainly due to the implementation of the national NHS computer system. We need to be able to prove that we have checked the eligibility of patients to receive NHS care. It is very important that patient's records, both paper and electronic, are matched with the correct patient.

If you have a record of your NHS number this will help us to get your records from your previous doctor quickly.

If you have any problems providing the information, please let us know.

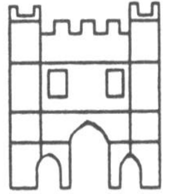
If you are from abroad we need to know the date that you entered the country, as this may affect your eligibility for hospital care.

Southgates Medical & Surgical Centre will always see patients in an emergency or as a temporary resident if you are not normally resident in this area.

We require a photocopy of one of the following documents:
Photo ID e.g. Passport or Driving Licence
OR
Current Utility Bill or Birth Certificate

Secs/forms/npm-ID

Southgates Medical & Surgical Centre



Welcome to Southgates Medical & Surgical Centre

Please complete *all* pages of the form

In order to make our medical care more efficient we would be grateful if you could complete this questionnaire and hand it into reception. Please tick the boxes and date where appropriate.

Title .... **Male/female** ……………………………………………………….

First name/s ....**Surname**...

Previous surname/s................................ **Date of birth** ……………………………………………………….

Address ....

Post Code ……………………......... **Town and country of Birth** ……………………………………….

Previous 3 addresses in UK ……………………………………………………………………………………………

……..

………

Name & address of previous doctor………………………………………………………………………………….

Occupation ………………………….. **NHS number** ……………………………………………………….

Tel (Home) ……………………………. **Email** ……………………………………………………….

If you provide an email address & photo id & you are 16 or over, we can send you details on how to book appointments & order repeat prescriptions online. If you would like to use this service please sign below.

………

Tel (Work) ……………………………. **Next of Kin**...

Tel (Mobile) ……………………………. **Name address and telephone no. for Next of Kin**………………...

………

It is practice policy to send GP appointment reminders to your mobile if a number has been provided. Please sign here if you **do not** want this service.

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 the 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

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

Ethnic Group (please tick relevant group)

A)	**White**		**B)**	**Asian**		**C)**	**Black**	
	British	☐		**British**	☐		**British**	☐
	Other White	☐		**Indian**	☐		**Other Black**	☐
				Pakistani	☐			
D	**Other**							

Please specify ……………………………………………………………………………………………………

Main Language Spoken ……………………………………………………………………………………………

Do you require an interpreter? Yes ☐ **No** ☐

Are you a carer for anyone aged over 16? Yes ☐ **No** ☐ If yes please ask our receptionists for a carers pack.

Do you have a carer? Yes ☐ **No** ☐

Height ……………………………………….cm **Weight** ……………………………………….kg

Tobacco

Do you smoke? Yes ☐ **No** ☐ **If YES, how many cigarettes/cigars do you smoke?** …......../day

If you currently don't smoke, have you ever smoked previously? Yes ☐ **No** ☐

Contraception
Please choose which type of contraception you currently use

Oral (the pill) ☐ **Diaphragm** ☐ **IUD (Coil)** ☐

Implant ☐ **Other** ……………………………………………

Do you suffer from any allergies or have you had any allergic reactions to any medications? (If yes, please state what you are allergic to).

Are you taking any repeat medications? Yes ☐ **No** ☐

If YES, please make an appointment 14 days prior to your medication being due.

Have you ever had any serious illnesses or operations? (If yes please state what they were).

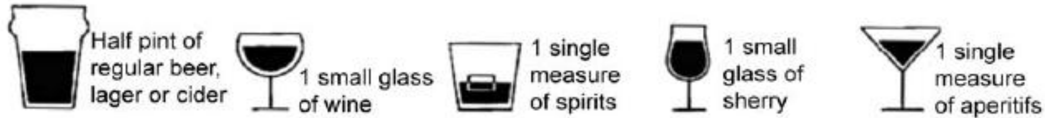
If you are aged 40 or over please make an appointment with the nurse for a blood pressure check.

Patient name……

Date of birth……..

Alcohol Consumption

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

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	
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+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Please continue overleaf - if your score ABOVE is more than 5

Score from AUDIT- C (other side)

Remaining AUDIT 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	
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	
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	
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	
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	
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	
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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions

Family History

Does any member of your immediate family have a history of the following conditions?

Asthma	☐	**High Blood Pressure**	☐	**Hypothyroidism**	☐
COPD	☐	**Heart Disease**	☐	**Stroke**	☐
Cancer	☐	**Epilepsy**	☐	**Diabetes**	☐
Genetic Illness	☐				

Signature of *patient / *on behalf of patient………………….…………………………… Date …………………………… (*please delete as appropriate)

Completion of this section is entirely voluntary

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

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

Signature confirming consent to organ donation

.... Date…………………..

For more information, ask for the leaflet on joining the NHS Organ Donor Register.

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 ……………….

NHS Smoking Cessation

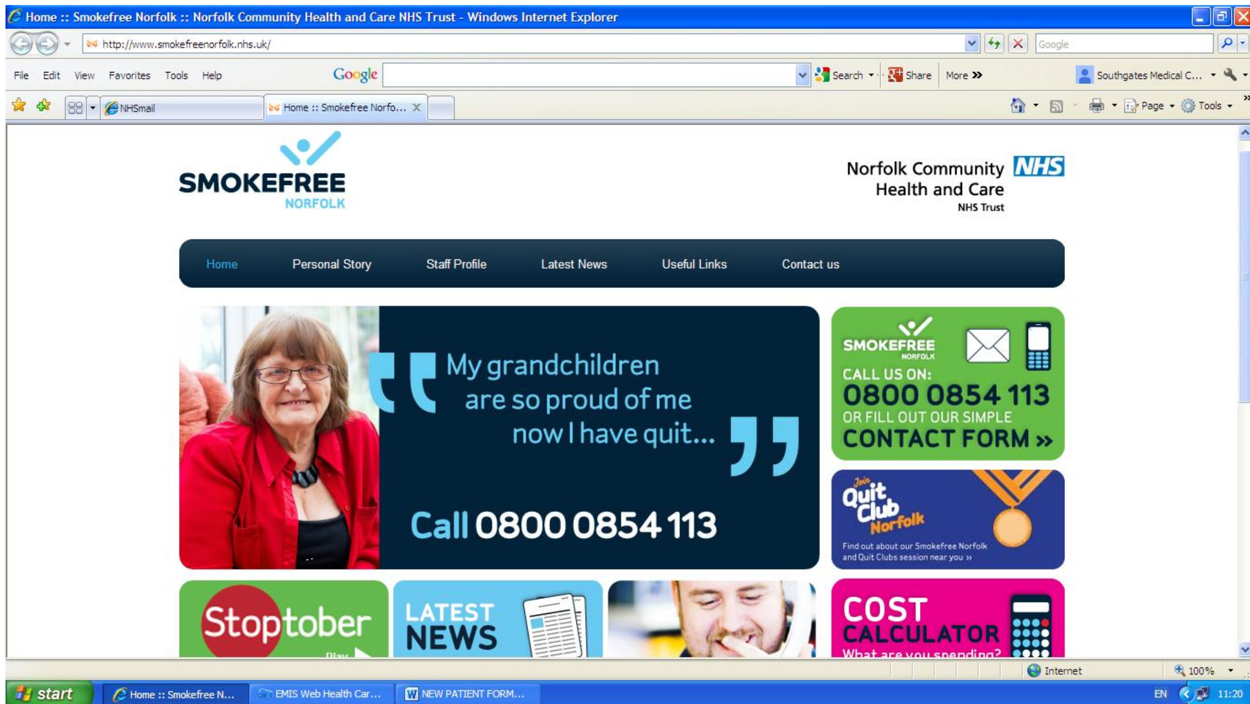
www.smokefree.nhs.uk

……………………………………………………………………………………………

Norfolk Stop Smoking Service

Website: www.smokefreenorfolk.nhs.uk

Telephone 0800 0854113



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EMIS Access

To provide our patients with greater accessibility we are introducing a system called EMIS Access. This system will allow patients who have been registered to perform the following tasks online:

- Book or cancel appointments
- Request repeat prescriptions
- Update personal details
- Send non-urgent messages

Please read the following guidelines before using EMIS Access for the first time.

Appointments

EMIS Access allows you to book **routine** appointments with a doctor; you will need to telephone the surgery to book an urgent appointment, home visit or a nurse's appointment. If you are unsure as to whether it is appropriate for you to see a nurse or a doctor please contact us by telephone. There are also some doctors appointments that you should not book yourself, these include:

- Coil fits
- Medicals
- Post-natals
- Ante-natals
- Surgical procedures
- Implants

If you have any queries regarding appointments please contact the surgery on 01553 819477.

Messaging

Please ensure that any messages sent to the surgery are non-urgent. Any patient messages should be responded to by the surgery within 2 working days.

Repeat prescriptions

Only a patients repeat prescriptions will be available to order. Please allow the usual 48 hours before collecting a prescription – 72 hours if you have requested that it is sent to a chemist.
If you have any queries regarding EMIS Access please contact Emma Batchelor at the following address: emma.batchelor@nhs.net

We are unable to provide EMIS ACCESS for children under the age of 16