Welcome to Fenham Hall Medical Group. Once we receive your registration forms, we may arrange for you to have an appointment with our pharmacy team or doctors.

If you have a long-term condition, for example high blood pressure or diabetes, we offer an annual review in your birthday month and we will contact you to arrange this.

If you are taking certain medications, we will need to discuss this with you as some medications are not recommended for long-term prescribing and may be harmful to you. These medications include:

* sleeping tablets like zopiclone, temazepam
* opioids like codeine, tramadol and morphine
* gabapentin and pregabalin
* diazepam and other benzodiazepines.

We follow the national and local recommendations for prescribing these medications and will discuss with you how best to reduce and stop these medications.

**Please complete ALL sections on this form in BLOCK CAPITALS and return with the purple GMS1 form, plus photographic ID (passport or driving license) or Birth Certificate AND an official letter with name and address (Utility Bill, Council Tax Bill, Bank Statement) dated within the last 3 months**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TITLE** | Mr / Mrs / Miss / Dr / Rev / Other | | | | |  | | |  |
| **DATE OF BIRTH** |  | | | | | **ARE YOU:** | | | **MALE / FEMALE** |
| **SURNAME** |  | | | | | **FORENAME** | | |  |
| **ANY PREVIOUS SURNAME(S)** |  | | | | | **MIDDLE NAME(S)** | | |  |
| **ADDRESS AND POSTCODE** |  | | | | | **HOME TELEPHONE**  **MOBILE NUMBER**  **EMAIL ADDRESS (we will provide online access)** | | | |
| **PLACE OF BIRTH** |  | | | | |
| **MAIN LANGUAGE SPOKEN** |  | | | | | Do you require an interpreter? **YES / NO**  If YES, is there a specific dialect needed? | | | |
|  |  | | | | |  | | | |
| **ARE YOU A CARER?** | | | **YES / NO**  If YES – please give name and contact telephone number | | | | | Are they registered at Fenham Hall Medical Group? | |
| **DO YOU HAVE A CARER?** | | | **YES / NO**  If YES – please give name and contact telephone number | | | | | Are they registered at Fenham Hall Medical Group? | |
| **ARE YOU A VETERAN OF THE BRITISH ARMED FORCES?** | | | **YES / NO** | | | | | | |
| **Would you like to become a member of our Patient Participation Group or Virtual Patient Participation Group?** | | | **YES/NO  Please specify which:** | | | | | | |
| Do you give consent for us to send you text messages or emails from the surgery? | | | | | | **TEXT**  **YES / NO**  **EMAIL YES / NO** | | | |
| Do you give consent for us to share your Summary Care Record with hospitals in an emergency situation? | | | | | | **YES / NO** | | | |
| **NEXT OF KIN DETAILS** Please provide details of your next of kin. | | | | | | | | | |
| **NAME** | |  | | | | | **MALE / FEMALE** | | |
| **CONTACT NUMBER** | |  | | | | | **RELATIONSHIP TO PATIENT** | | |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | | | | | | | **YES / NO** | | |
| **EMERGENCY CONTACT** Please give details of the person we should contact on your behalf in case of an emergency (if this person is not your next of kin) | | | | | | | | | |
| **NAME** | |  | | | | | **MALE / FEMALE** | | |
| **CONTACT NUMBER** | |  | | | | | **RELATIONSHIP TO PATIENT** | | |
| **DO YOU GIVE US PERMISSION TO DISCUSS YOUR CARE WITH THIS PERSON IN AN EMERGENCY?** | | | | | | | **YES / NO** | | |
|  | | | |  | | | | | |
| **DO YOU SMOKE?** | | | | **YES / EX-SMOKER / NEVER SMOKED** | | | | | |
|  | | | | If **yes**, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ cigarettes / cigars / pipe  If an **ex-smoker**, when did you give up? | | | | | |
| **ARE YOU ALLERGIC TO ANYTHING?** | | | | **YES / NO** | If yes, please provide details | | | | |
| Please detail any communication needs that you have (e.g. large print letters, braille, hearing) | | | | | | | | | |
|  | | | | | | | | | |
| Providing you have an email address, you will automatically be registered for our Online Services, to enable you to order repeat medications.  Your prescriptions will be sent electronically to a pharmacy of your choice. Please let us know which Pharmacy you wish to use **here –**  **MY NOMINATED PHARMACY IS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **IF ANY OF THIS INFORMATION CHANGES IN THE FUTURE PLEASE NOTIFY THE SURGERY, IN WRITING OR BY EMAIL, AS SOON AS POSSIBLE.** | | | | | | | | | |

**ALCOHOL USE DISORDERS IDENTIFICATION TEST CONSUMPTION (AUDIT C)**

This alcohol harm assessment tool consists of the consumption questions from the full alcohol use disorders identification test (AUDIT).

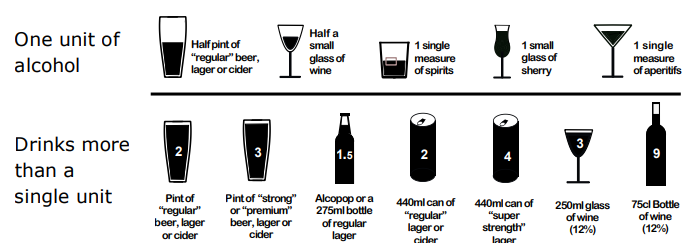
|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per month | 2 to 3 times per week | 4 or more times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more |  |
| 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 |  |
| **AUDIT C Score** |  | | | | | |

**Scoring:**● A total of 5 or more is a positive screen   
● 0 to 4 indicates low risk   
● 5 to 7 indicates increasing risk   
● 8 to10 indicates higher risk   
● 11 to 12 indicates possible dependence  
  
**What to do next**

If you have a score of 5 or more and time permits, please complete the remaining alcohol harm questions below to obtain a full AUDIT score.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |  |

|  |  |
| --- | --- |
| **Total AUDIT score** |  |

**Alcohol unit reference**