

**Patient's details**

Please complete in BLOCK CAPITALS and tick  as Appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Surname	
Date of birth	d	d	m
			y
First names		NHS No.	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Town and country of birth	
Ethnic Origin		First Language	
Home address			
Postcode		Telephone No:	Mobile No:
Are you a carer? <input type="checkbox"/>		Do you have a carer? <input type="checkbox"/>	Are you registered Disabled? <input type="checkbox"/>

**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	Date Left

**If you are registering a child under five.**

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  
 I would have serious difficulty in getting them from a chemist

*\* Not all doctors are authorised to dispense medicines.*

Signature of Patient     Signature on behalf of patient    Date

**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

*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 0845 60 60 400*

**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 three 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 the 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

Practice Stamp

Name

Date

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

## Meeting Everyone's Health Needs

We would be very grateful if you could take time to complete this form. Please be assured that any information given will be treated confidentially. If you have any queries about completing this form, please ask a member of staff. For question 1, if you feel you are descended from more than one group, please tick the one you feel you most belong to or choose the "Any Other Ethnic Group" option. We are also asking your religion, preferred language, whether you have a disability, your smoking and alcohol status, if you are a Carer and BMI (height and weight). Again this is to help us ensure we meet your health care needs appropriately.

When you have completed the form, please return with the enclosed registration. Thank you.

**What is your Ethnic Group?** Choose ONE section only

**White**

- British
- Irish
- Any Other White background (please state) .....

**Mixed**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background (please state) .....

**Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please state) .....

**Black or Black British**

- Caribbean
- Africa
- Any other Black background (please state) .....

**Any Other Ethnic Group**

- Chinese
- Vietnamese
- Any Other (please state) .....
- Do not wish to state

**Do you have a disability/impairment (e.g. Hearing, Vision, Mobility)**       Yes       No

**Details**

.....

.....

**Please turn over and complete all sections - Thank you**

**What is your Religion (tick one box only)**

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> None      | <input type="checkbox"/> Church of England | <input type="checkbox"/> Roman Catholic    |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Buddhist          | <input type="checkbox"/> Hindu             |
| <input type="checkbox"/> Jewish    | <input type="checkbox"/> Islam             | <input type="checkbox"/> Jehovah's Witness |
- Other (please state) .....
- Do not wish to state

**What is Your Preferred Language (Please choose ONE)**

	Spoken	Written
English	<input type="checkbox"/>	<input type="checkbox"/>
Vietnamese	<input type="checkbox"/>	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	<input type="checkbox"/>
Hindi	<input type="checkbox"/>	<input type="checkbox"/>
Panjabi	<input type="checkbox"/>	<input type="checkbox"/>
Urdu	<input type="checkbox"/>	<input type="checkbox"/>
Cantonese	<input type="checkbox"/>	<input type="checkbox"/>
British Sign Language	<input type="checkbox"/>	<input type="checkbox"/>

Other (please state) .....

**Please Enter Your Smoking Status**

- Never Smoked       Current Smoker - amount per day =

**Ex Smoker - Please Enter Date Stopped**

- Ex Light Smoker (1 to 9 per day)      Date Stopped .....
- Ex Moderate Smoker (10 to 19 per day)      Date Stopped .....
- Ex Heavy Smoker (20 to 39 per day)      Date Stopped .....
- Ex Heavy Smoker (40 + per day)      Date Stopped .....

If you are a **Current Smoker** and would like help in stopping - please tick this box  so that we can offer you help with this.

Height .....

Weight .....

**Alcohol Intake**

**How often do you have a drink containing Alcohol?**

- Never       Monthly or less       2-4 times / Month
- 2-3 times / Week       4 + time / Week

How many Standard drinks containing Alcohol do you have on a typical Day?

- None       1 or 2       3 or 4       5 or 6  
 7 to 9       10 or more

How often do you have six or more drink on one occasion?

- Never       Less than Monthly       Monthly  
 Weekly       Daily or almost Daily

In order for us to update your Clinical Records accurately, please complete the following:

Surname ..... First Name(s).....

Address .....

Postcode ..... Date of Birth .....

Telephone Number ..... Mobile No. ....

Date .....

Next of Kin (please complete the following)

Surname ..... First Name(s).....

Address .....

Postcode ..... Date of Birth .....

Telephone Number ..... Mobile No. ....

Date .....

Please inform us IMMEDIATELY of any changes of Address or Phone Numbers

Thank you for completing this form

## Consent to Register with ElderCare

**How did you hear about ElderCare?**

- Nursing Home                       Relative/friend                       Newspaper  
 Other (please state).....

**What made you decide to choose ElderCare?**

- .....
- I have been issued with a registration pack for ElderCare with a full list of services provided.  
 I understand as part of the governments patient choice agenda, I am free to choose who provides my GP medical services.

A full list of other local G.P's who are registering patients for G.P medical services in the area can be obtained by contacting:

NHS Central Operations Mersey  
 Bevan House  
 65 Stephenson Way  
 Wavertree Technology Park  
 Wavertree  
 Liverpool  
 L13 1HN  
 0151 296 7000

- I understand that by signing this consent form I am agreeing to register as a patient of ElderCare.

**Signature**.....                      **Name**.....

**Date** .....

If completing on behalf of a relative please ensure the **Next of Kin completes the following:-**

**Signature**.....                      **Name**.....

**Date** .....                      **Relationship to patient:**.....

When you have completed the above, please return to ElderCare with the purple registration form. Please note this consent form must be completed before your registration can be processed.

**Thank you**

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Managed by Aspect Health - Local GPs providing local healthcare.

