SOUTHBOURNE SURGERY
NEW PATIENT REGISTRATION DETAILS
(for over 14 years)

Date of Registration: ……..

First name ……..

Surname …….

Date of Birth ……

Mobile number ……..
(**MUST BE A PERSONAL MOBILE NUMBER)**
Telephone Number ……..

I give permission for messages to be left on my phone: **Yes** / **No**
If you have supplied a mobile number you will receive text message appointment reminders and occasional messages. Please note here if you do not want text messages……..

Do you have any information or communication needs? ie: a disability, impairment or sensory loss. If yes our aim is to meet those needs and to enable you to access and receive information in a way you can understand. Please give details and how we can meet those needs……..
……

Would you like to have a Summary Care Record? **Yes** / **No** **Please answer!**
(Information on your current medication, any allergies or bad reactions to medicines are held on a national database. Please see leaflet for further details)

We can now send your prescriptions electronically to a local pharmacy for you. If you would like to do this, please ensure that you read and understood the 'Electronic Prescription Service' leaflet, and please note that if you wish to change your nominated pharmacy, you must let us know.
Please tick your preferred pharmacy (only one choice) to collect your medication from:

1. Boots, Southbourne PO10 8JG ☐
2. The Old Pharmacy, Emsworth PO10 7AN ☐
3. Tesco, Fishbourne Chichester PO19 3JT ☐
4. Rowlands, Westbourne PO10 8UJ ☐
5. Lloyds, Emsworth PO10 7DU ☐
6. Other (must include postcode)……

FOR ONLINE BOOKINGS, REPEAT PRESCRIPTIONS & ONLINE TEST RESULTS, please ask for additional form

Ethnicity: British (white) ☐ Other …… First Language: English ☐ or other ……
: Would prefer not to say ☐
I have never smoked ☐ I am an ex smoker ☐ I am a current smoker ☐
If you are a **current smoker** we are required to offer BOTH support and treatment to stop smoking. **Please tick below**
I am **not interested** in either support/treatment ☐ I **am interested** in either support/treatment ☐
I am a carer for a friend or relative ☐ I have a carer ☐ (Carers information is available in the reception area)

Alcohol Questionnaire –please fill in below

QUESTIONS	SCORING SYSTEM 0	1	2	3	4	YOUR SCORE
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is 2 or higher						
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, doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, on one occasion		Yes, on more than one occasion	

IF (only if) you score 3 or more above, please fill in the additional questionnaire overleaf. PTO

We offer a new patient check which will include a blood pressure check, your weight and height, urine check etc. Please book at reception if you would like this, please bring a urine sample with you to your appointment.

Patient – I have a copy of the patient guidance notes for use of SystmOne online if I am requesting online access and agree to keep my user details secure and confidential.

Signed (patient) …….. **Date……**

Please hand back to the receptionist to fill in surgery details.
SURGERY SCANNERS – form MUST be scanned double sided

PTO

For the patient: Please fill in below if your score is 3 or more on the previous page
Alcohol Users Disorders Identification Test (AUDIT)

QUESTIONS	SCORING SYSTEM 0	1	2	3	4	YOUR SCORE
How often do you have a drink that contains alcohol	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 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	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in 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 in 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 in 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 in 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, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not the last year		Yes, during the last year	
Alcohol use disorders identification test Total *If your total is 8 or above, please make an appointment to discuss with our practice nurse*						

Scoring: 0 - 7 = lower risk, 8 – 15 = hazardous drinking, 16 – 19 = harmful drinking, and 20+ = possible dependence

For surgery use …..

Smoking advice :– Already has a smoking appt booked / text sent / letter sent
AUDIT alcohol details *(if score of 8 or above)* : – Already has appt to discuss alcohol / Text sent / letter sent re nurse appt

Registered GP (surgery will enter)	**Patient Informed** (tick if told at time of registering, if not told when registering, over 74 year olds MUST be informed now - please detail how pt has now been informed	Name of staff who has informed patient

Registration details entered by …… Date ……. ***Scanners – MUST SCAN DOUBLE SIDED PLEASE***