

Registration Check List (HSCR1)

Please ensure that all boxes are ticked before returning

Templepatrick Surgery Registration Form	
HSCR1 form	
One document from each of the lists on the back of the HSCR1 form (3 supporting documents in total)	
Summary from previous GP if possible	

Incomplete forms cannot be accepted

Admin use only:

Templepatrick Surgery

New Patient Questionnaire

Thank you for taking the time to complete this questionnaire. The information given is strictly confidential and is important for the nurse or GP who may need to treat you before we have your medical records from your previous GP. You will need **one photographic form of identity** plus **proof of address** such as a utility bill, bank statement, solicitor's letter but not a mobile phone bill.

Please ensure you complete all sections of this form

Date form completed:	
Title: Mr/Mrs/Miss/Dr/Other _____	Surname:
Date of Birth:	First Names:
Address:	Previous Surname:
Postcode:	Home Telephone No:
Mobile Phone No:	Marital Status:
We may wish to contact you by text. Please tick and sign if you <u>do not</u> wish us to do so <input type="checkbox"/> _____	
Ethnicity: British <input type="checkbox"/> Irish <input type="checkbox"/> Other please specify _____	
Have you ever been registered at Templepatrick Surgery? Yes/No	

Next of Kin	
Name:	Relationship:
Address:	Home Telephone No:
	Mobile Telephone No:

Are You a Carer: Yes/No	
Name of person you care for:	Relationship to person you care for:
Is the person you care for registered at this surgery? Yes/No	

Do you have a hearing impairment? If so please clarify if :

- ☐ Bilateral
- ☐ Left Sided
- ☐ Right Sided

How would you like us to communicate with you?

PAST MEDICAL HISTORY

Please inform us if you have or previously suffered from any of the following conditions

	Yes/No		Yes/No
Asthma		COPD	
Diabetes (Type 1 or Type 2)		Rheumatoid Arthritis	
Heart Disease		Stroke	
Chronic Kidney Disease		Cancer (please specify type)	
Other (please specify)			
<u>ALLERGIES (PLEASE LIST ALL DRUG & NON DRUG ALLERGIES)</u>			

OVER 18S ONLY

Alcohol Screening - Using the guide below please state how many

Units per week you take? _____ **Units per week.**



Pint of beer
(4%)
= 2.3 units



Pint of cider
(5%)
= 2.8 units



Alcopop
(5%/275ml)
= 1.4 units



Can/bottle of beer
(5%/330ml)
= 1.7 units



Spirits eg vodka/whiskey
(40%/35ml)
= 1.4 units



Bottle of spirits
(40%/700ml)
= 28 units



Bottle of wine
(12%/750ml)
= 9 units



Small pub bottle of wine
(12%/187.5ml)
= 2.3 units

The maximum recommended units per week are 14 for men and women. Consistently drinking more than the recommended units per week can have major problems to your health. If you would like help please make an appointment with one of the nurses or doctors to discuss.

SMOKING STATUS

If you are currently a smoker and want to consider stopping please speak to reception or contact your local pharmacy. Alternatively for further information you can access ***Stopsmokingni.info***.

- ☐ Current smoker – how many cigs per day_____
- ☐ Vaping/ E-Cigarette
- ☐ Ex- Smoker – approx. year stopped_____
- ☐ Never smoked tobacco

Practice Medication Policy

The drugs listed below can be dangerous long-term. Practice policy is to reduce these drugs through a reduction programme.

****Diazepam, Temazepam, Nitrazepam, Lorazepam, Zopiclone, Zolpidem, Dihydrocodeine, Codeine, Morphine, Fentanyl and any other opiates**** Pregabalin (Lyrica) is no longer recommended for prescribing in Northern Ireland.

If you are currently being prescribed any of these drugs please sign below that you are prepared to consent to a reduction strategy in the future.

- ☐ I have read and understood the Practice Policy on these drugs and I agree to a reduction programme when recommended by GP.
- ☐ I understand that any current reduction programme for medications above will continue as planned.
- ☐ I do not take any of the above medication.

Signature: _____

Date: _____

Under no circumstances will the practice replace lost or stolen scripts or medication.