Welcome to Fairview Medical Centre. It may take several weeks for your records to reach us from your previous surgery. To help us care for you please complete this form. The information is confidential. If you have any queries or concerns do not hesitate to contact us: **020 8765 8525** or email: **swlccg.fairview@nhs.net**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: |  | Telephone: |  |
| First Name: |  | Email: |  |

We are required by law to ask for your ethnic background, your first language and main spoken language. Please select (by highlighting) the option you feel best describes you.

|  |  |  |  |
| --- | --- | --- | --- |
| **White:** | **Mixed:** | **Asian/Asian British:** | **Black/Black British:** |
| British | White/Caribbean | Indian | African |
| Irish | White/African | Pakistani | Caribbean |
| Other White | White/Asian | Bangladeshi | Other Black |
|  | Other Mixed | Other Asian |  |

|  |  |  |
| --- | --- | --- |
| **First Spoken Language:** | **Main Spoken Language:** | **Do You Speak English?** |
|  |  | YES / NO |

|  |  |
| --- | --- |
| **Place of Birth:** |  |

We also require some personal information:

|  |  |  |  |
| --- | --- | --- | --- |
| **Height:** |  | **Weight:** |  |

*Enter* ***Y or a tick*** *in the appropriate box*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No Exercise:** |  | **Some Exercise:** |  | **Exercise 3 or more times per week:** |  |  |

*Highlight the appropriate option*

|  |  |  |
| --- | --- | --- |
| **Have you ever smoked?** | **Do you smoke now?** | **If yes how many per day?** |
| YES / NO | YES / NO |  |

If you do smoke and wish to give up we offer a comprehensive stop smoking programme which may include the prescribing of nicotine replacement patches or other medicines. This is a free NHS services for all our patients.

|  |  |
| --- | --- |
| **How many units of alcohol do you drink per week on average? :** |  |

(2 units = 1 glass of wine, 1 pint of beer/cider, 1 single measure of spirits)

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have a Carer? :** | YES / NO | **Name:** |  |
| **Telephone:** |  | **Relationship:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Would you consider registering as an organ donor?** | YES |  | NO |  |  |

|  |
| --- |
| **Do you consent to Summary Care Record? Please tick or enter ‘Y’ on ONE of the following:** |
| **Express consent for medication, allergies, and adverse reactions only** |  |

|  |  |
| --- | --- |
| **Express consent for medication, allergies, adverse reactions, AND additional information** |  |

|  |  |
| --- | --- |
| **Express dissent (opt out)** |  |

**Please answer further questions overleaf/ on the next page**

|  |
| --- |
| **Do you have any medical condition? If so, please provide details of your medication:** |
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| --- |
| **Are you on any medication? If so, please provide details of your medication:**  |
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| --- |
| **Next of Kin: Please provide THEIR details**  |

|  |  |
| --- | --- |
| **Name:** |  |
| **Relationship:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Contact Number:** |  |
| **Emergency Contact:** | YES / NO |
| **Discuss Records:** | YES / NO |
| **Are they registered at Fairview?** | YES / NO |

|  |
| --- |
| **Patient Signature**  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **X** |  | **Date Signed:** |  | / |  | / |  |

**REQUIRED DOCUMENTS:** *(please tick or click on the boxes to indicate documents you have and will submit)*

|  |  |
| --- | --- |
| ***All adults must please provide:*** | ***For all children we need to see:*** |
| [ ]  ***original photo ID (passport*** | [ ]  ***original birth certificate/passport*** |
| [ ]  ***proof of address (utility bill)*** | [ ]  ***their red book please.***  |
| [ ]  ***completed Registration Form*** | [ ]  ***completed Registration Form*** |
| [ ]  ***completed Additional Information Registration Form (this form)*** | [ ]  ***completed Additional Information Registration Form (this form)*** |
| [ ]  ***If you or your child(ren) are on regular medication, please provide proof of all your medication.***  |

**PLEASE submit completed registration forms and required documents to the surgery via:**

* **Email:** **swlccg.fairview@nhs.net****OR**
* **Bring / Post To**: **Fairview Medical Centre, 69 Fairview Road, London SW16 5PX**

***Thank you.***