

PENRYN SURGERY- UNIVERSITY STUDENT REGISTRATION (Please complete all 3 pages)

SURGERY USE ONLY ID Seen :	
Other info. from patient :	

Information & Communication Needs :

Please let us know if you have any information or communication needs. This may include large print, sign language interpreter or hearing aid communication tool. We will make a note of this on your records and support you with this during future contacts with the Practice.

MR/MRS/MISS/OTHER FIRST NAME.....

LAST NAME

DATE OF BIRTH (Date/Month/Year).....

Mobile No :

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

E-mail Address :

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(By providing your e-mail address and mobile number you consent to us contacting you by these methods of communication for Direct Patient Care – including national screening programmes - Please bear this in mind if you share an e-mail account)

Transgender patients :

Male to Female Female to Male

We may need to ask you for further information to be able to locate your medical records – we can either discuss this with you today or will contact you in the near future.

HEIGHT : **WEIGHT :**

Course Dates :

Proposed Course End Date :

ETHNIC CATEGORY (please circle ONE only)

WHITE	MIXED
A British	D White and Black Caribbean
B Irish	E White and Black African
C Any other White background	F White and Asian
	G Any other mixed background
ASIAN OR ASIAN BRITISH	BLACK OR BLACK BRITISH
H Indian	M Caribbean
J Pakistani	N African
K Bangladeshi	P Any other Black background
L Any other Asian background	
OTHER ETHNIC GROUPS	
R Chinese	Z Not stated
S Any other ethnic group	

PLEASE STATE YOUR FIRST LANGUAGE.....

RELIGION

<p>SMOKING: Are you a :</p> <p>Current smoker <input type="checkbox"/></p> <p>Ex smoker <input type="checkbox"/></p> <p>Never smoked <input type="checkbox"/></p>	<p>STOP SMOKING</p> <p>If you are interested in help and advice we have Stop Smoking, information is available at reception at our Surgeries.</p>
--	--

ALCOHOL

How many units of alcohol do you drink per week?
 0 1-14 15-21 22-28 36-42 43-49 50 or over

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 monthly or more					
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/ health worker been concerned about your drinking or advised you to cut down?	NO		YES BUT NOT IN THE LAST YEAR		YES, DURING THE LAST YEAR

MEDICAL HISTORY – That requires current treatment and/or regular medication

Asthma Hypertension Heart disease

Kidney Disease Hypothyroidism ADHD- requiring

Diabetes Epilepsy medication

Other :

.....

MEDICATION :

If you take regular medication, please attach a copy of your most recent prescription counterfoil or ask your present GP Practice for a copy of the counterfoil to include with this form.

Vaccinations :

Have you had the MenACWY vaccine, to protect you from Meningococcal groups A, C, W and Y?

Yes Date No If you are over 18, and this is your first ever year at a University, you will be eligible for this vaccine, and the surgery will be in contact with you.

We may also be in contact with you if we need further information about the vaccinations you have received.

Overseas student ? We will need you to supply to us a list of the vaccinations you have received.

FEMALES ONLY

- Do you have a contraceptive coil fitted at present? YES / NO
- If so, what date did you have the coil fitted?
- Do you have a contraceptive implant fitted at present? YES / NO
- If so, what date did you have the contraceptive implant fitted?

CONSENT TO SHARE DATA :

1) Summary Care Records :

A Summary Care record is an electronic record that can help give you safer, faster care by giving healthcare staff instant access to information about your MEDICINES, ALLERGIES and MEDICINES WHICH MAKE YOU ILL.

- I would like to share my Summary Care Record
- I **do not** wish to share my Summary Care Record

2) Enhanced Data Sharing Model :

SystemOne is the clinical computer system used by Penryn Surgery. Opting into this method of sharing your medical information will allow other services who use this same clinical computer system, eg District Nurses, to access your medical record but **ONLY** if they have need to do so for your clinical care.

Do you consent to the sharing of data recorded here with any other organisations that may care you ?

- Yes
- No

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you and where you have agreed to make the data shareable?

- Yes
- No

3) National Data opt-out :

Information about your health and care helps the NHS to improve your individual care, speed up diagnosis, plan your local services and research new treatments. In May 2018 strict rules about how this data can and cannot be used were strengthened. You can choose whether your confidential patient information is used for research and planning.

To find out more visit : [nhs.uk/your-nhs-data-matters](https://www.nhs.uk/your-nhs-data-matters)

Further information about data sharing can be found on [nhs.uk](https://www.nhs.uk) or digital.nhs.uk

The Practice's Privacy Policies, (prepared in line with GDPR requirements), can be viewed in our waiting rooms and on our website www.penryn.co.uk

Please note: any information you give on this form will only be used by the Penryn Surgery in conjunction with your health needs and will not be passed to any third parties.

PENRYN SURGERY

Name : _____

Date of birth : _____

I give consent to allow the Practice to discuss medical matters with my parents, next of kin, guardian or nominated person : (This consent will remain on my notes until I advise the surgery otherwise)

No

Yes

Name of person if "yes" : _____

Relationship to me if "yes" : _____

Telephone number of person if "yes" : _____

Your signature : _____ **Today's date :** _____