



## THE HAVEN PRACTICE

### Welcome to Your Practice

We would appreciate it, if you could take a few moments to answer the questions listed here so that we have some basic information about you and your health. We hope to offer you all the information you may need, through our Reception staff at the Surgery, our Practice Leaflet and our Practice Website.

|   |           |
|---|-----------|
| Surname:  | Forename: |
| Date of Birth:  | Landline: |
| Mobile No:  | E-Mail:   |
| Are you a Carer?<br>A Carer is someone who regularly, and without payment looks after or supports a person who is ill, disabled, frail or in need of emotional support)   | Yes/No    |
| Does someone Care for you?  | Yes/No    |
| <b>ILLNESSES:</b><br>Have you had any serious illness?<br>Do you have any medical problems at the moment?<br>Please list any allergies you have:<br>Please list any tablets, medicine or other treatments you are taking or bought from a chemist:<br>Are there any serious diseases that affect your family? |           |
| <b>Next of Kin:</b><br>Name:<br>Relationship:<br>Contact Details:   |           |
| <b>Religion:</b>  |           |

|  |  |
|--|--|
| <b>IMMUNISATIONS:</b>  | Pneumococcal   |
| Please circle which Immunisations you have been given:                   |  |
| Diphtheria/Tetanus/Polio   | Measles/Mumps/Rubella  |
| Pertussis (Whooping cough)   | German Measles   |
| HPV (Cervical Cancer)  | Meningitis C   |
| <b>YOUR HEALTH:</b>  |  |
| Do you smoke? Yes/No   | If so, how many a day?   |
| Have you ever smoked? Yes/No   |  |
| Do you drink alcohol? Yes/No   | If so, how many units a week?  |
| What kind of exercise do you take?                                       |  |
| Approx. weight and height?   | Weight:                      Height:                                   |
| Are you on any special diet?   |  |
| <b>GENDER</b>  |  |
| Male   | Female   |
| Transgender  |  |
| <b>SEXUAL ORIENTATION</b>  |  |
| Do not wish to enclose   |  |
| Gay  | Bisexual   |
| Lesbian  | Heterosexual   |
| <b>ETHNICITY:</b> Please Circle:   | Main Language Spoken:  |
| British/Mixed British  | Irish  |
| Other White Background   | White and Black Caribbean  |
| White and Black African  | Indian/British Indian  |
| Other Mixed Background   | Bangladeshi/British Bangladeshi  |
| Pakistani/British Pakistani  | Caribbean  |
| Other Asian Background   | Other Black Background   |
| African  | White and Asian  |
| Chinese  | Other  |
| <b>UNDER 25'S, OVER 40'S &amp; 60'S</b>                                  |  |
| <b>Under 25's:</b> Have you ever had a Chlamydia test?                   | <b>Over 60's:</b> Have you had Bowel Cancer screening in last 5 years? |
| <b>Over 40's:</b> Have you had a Cholesterol Blood test in last 5 years? |  |
| <b>WOMENS HEALTH ONLY</b>  |  |
| Have you had a Mammogram?  | If so, when?   |
| When was your last smear?  |  |

## Patient Information Sharing and Consent

All information you give to us is safeguarded by the Data Protection Act and the NHS Care Record Guarantee. At all times, everyone working for the NHS, has a legal duty to keep information about you confidential. However, information is sometimes shared where it is absolutely necessary to support your care or help improve the service provided by the NHS.

**You have a choice about whether your information is shared and for what purpose.**

Please complete the boxes below to tell us what your choices are:

|   |   |
|---|---|
| <b>SUMMARY CARE RECORD:</b>   |   |
| A summary care record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely | If <b>Yes</b> a record will be created for you, but you can opt-out at any time. If <b>No</b> , please ask for an-opt out form at reception |
|   |   |
| Do you want a Summary Care Record?  | Yes/No  |
|   |   |
| <b>CARE DATA:</b>   |   |
| The NHS uses information about you and the care you receive to help plan and improve services. The information will be held securely and includes your postcode and NHS number but <b>NOT</b> your name                             |   |
| Do you agree that your GP records maybe used for planning and research purposes outside the Practice?   | Yes/No  |
| Do you agree that your information held by other places you receive care, such as Hospitals and Community Services may be used for planning and research purposes?  | Yes/No  |
|   |   |



## THE HAVEN PRACTICE

### Application Form for Online Services Patient Access

I would like to apply for access to book Appointments, order Repeat Prescriptions and have access to my Medical Record online, this would include, viewing Letters and attachments, Test results and Immunisation history, Consultations, update Contact details.

**ID is not required if you are an active registered Patient.** Passwords can only be given to patients in person and not by email or post and will be ready at Reception for collection within five working days.

|  |  |
|--|--|
| Patients Name:   |  |
| Date of Birth:   |  |
| Home Tel:  |  |
| Mobile No:   |  |
| Email Address:   |  |
| Patients Signature:  |  |
| Date:  |  |
| Where the patient is under the age of 14, online access may be applied for by a person holding Parental Responsibility. All patients attaining the age of 14 years will be required to apply for access for this service to be continued. If the Patient is between the age of 14 and 16 they can consent to the person holding Parental Responsibility to have access, please complete below. |  |
| Name of person holding Parental Responsibility:  |  |
| I consent to the person above holding Parental Responsibility to have access to my records:  |  |
| Signature:   |  |
| Date:  |  |

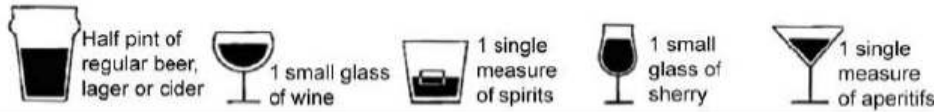
- I understand I will not be able to use this code to book appointments/order repeat prescriptions, access medical record for any other patient
- I understand that I remain responsible for notifying the Practice of any change in contact details
- I understand that I remain responsible for attending or cancelling appointments
- I understand that the Practice reserves the right to withdraw this access if this service is used inappropriately.

Email to: [BHCCG.TheHaven@nhs.net](mailto:BHCCG.TheHaven@nhs.net)

## Appendix B: ADULT ALCOHOL SCREENING TOOL

### UNIT GUIDE

This is one unit of alcohol...



Weekly Unit Consumption

...and each of these is more than one unit



Two or more alcohol free days

Yes / No

The following questions are validated as screening tools for alcohol use

| AUDIT - C: First 3 Questions   | Scoring system   |                   |                               |                    |                           | Your score |
|--|--|-------------------|-------------------------------|--------------------|---------------------------|------------|
|  | 0  | 1                 | 2                             | 3                  | 4                         |            |
| How often do you have a drink containing alcohol?  | Never  | Monthly or less   | 2-4 times per month           | 2-3 times per week | 4+ times per week         |            |
| How many units of alcohol do you drink on a typical day when you are drinking?   | 1-2  | 3-4               | 5-6                           | 7-9                | 10+                       |            |
| How often have you had 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     |            |
| <b>Full AUDIT: Remaining 7 Questions</b>   | <b>AUDIT C Score</b><br>Complete Full Audit if score is greater than 5 |                   |                               |                    |                           |            |
| How often during the last year have you found that you were not able to stop drinking once you had started?                            | Never  | Less than monthly | Monthly                       | Weekly             | Daily or almost daily     |            |
| How often during 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 during 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 during 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 during 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?             | No   |                   | Yes, but not in the last year |                    | Yes, during the last year |            |
| Score equals   |  |                   |                               |                    |                           |            |
| TOTAL score equals = AUDIT C score (above) + score of remaining 7 questions  |  |                   |                               |                    |                           |            |

**PLEASE TURN OVER for scoring & next steps >>>>>**

## AUDIT ALCOHOL SCREENING TOOL

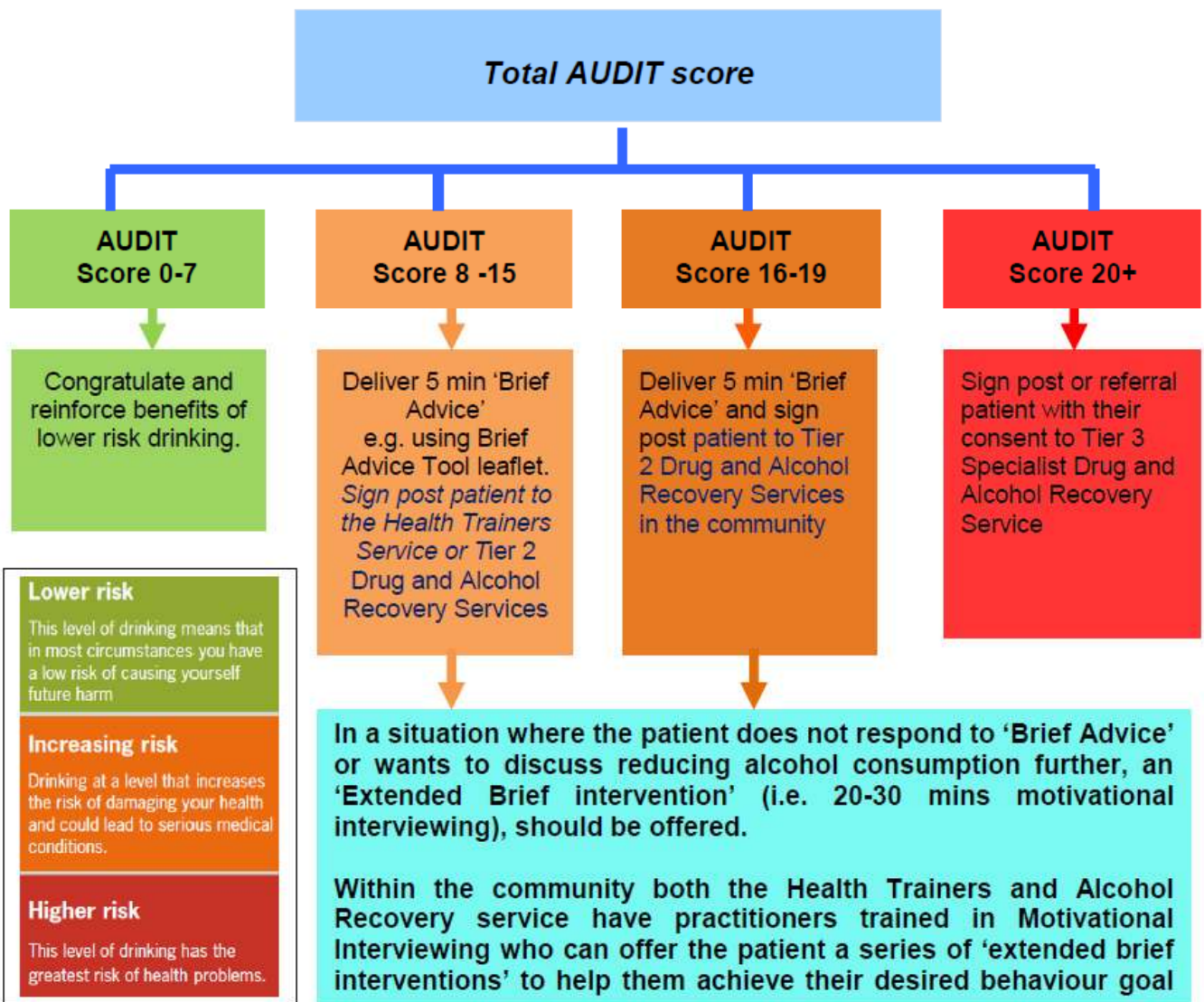
**SCORING: ADD all ten scores together to identify necessary action (e.g. Brief Advice)**

Total AUDIT score

“Based on your answers, your drinking places you in the ... risk category.”  
(for 8+ scores lead to Brief Advice with) “How do you feel about that?”

| AUDIT SCORE | RISK CATEGORY       | = | DESIRED ACTION                       |
|-------------|---------------------|---|--------------------------------------|
| 0 –7        | Lower risk          | = | No intervention required             |
| 8 –15       | Increasing risk     | = | Brief Advice and sign post to Tier 2 |
| 16-19       | Higher risk         | = | Brief Advice and sign post to Tier 2 |
| 20+         | Possible dependence | = | Referral to Tier 3 services)         |

### Identification and Brief Advice (IBA) pathway



For Brief Intervention/IBA tools and e-learning visit  
[www.alcohollearningcentre.org.uk](http://www.alcohollearningcentre.org.uk) and see 'topics: 'IBA'

4. Do you have a disability, impairment or Sensory loss and need to receive information in a way you can easily understand?

Please tick

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**Large Print**



**Braille**



**Via Email**



**Hearing Impaired**



**Alternative Languages**



**Other Support**

if required, like British Sign Language (BSL)

OTHER: .....

5. Please state if ;

13VC You have a disability?

13VC5 You have a disability?  
(e.g. Do you have a Blue Badge, or claim any disability allowance etc)