

IMMUNISATIONS:	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
YOUR HEALTH:	
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?	
GENDER	
Male	Female
Transgender	
SEXUAL ORIENTATION	
Do not wish to enclose	
Gay	Bisexual
Lesbian	Heterosexual
ETHNICITY: 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
UNDER 25'S, OVER 40'S & 60'S	
Under 25's: Have you ever had a Chlamydia test?	Over 60's: Have you had Bowel Cancer screening in last 5 years?
Over 40's: Have you had a Cholesterol Blood test in last 5 years?	
WOMENS HEALTH ONLY	
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:

SUMMARY CARE RECORD:	
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 Yes a record will be created for you, but you can opt-out at any time. If No , please ask for an-opt out form at reception
Do you want a Summary Care Record?	Yes/No
CARE DATA:	
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 NOT 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:	

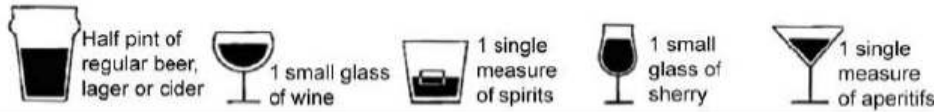
- I understand I will not be able to use this code to book appointments/order repeat prescriptions, access medical record for any other patient
- I understand that I remain responsible for notifying the Practice of any change in contact details
- I understand that I remain responsible for attending or 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

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	
Full AUDIT: Remaining 7 Questions	AUDIT C Score					
	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

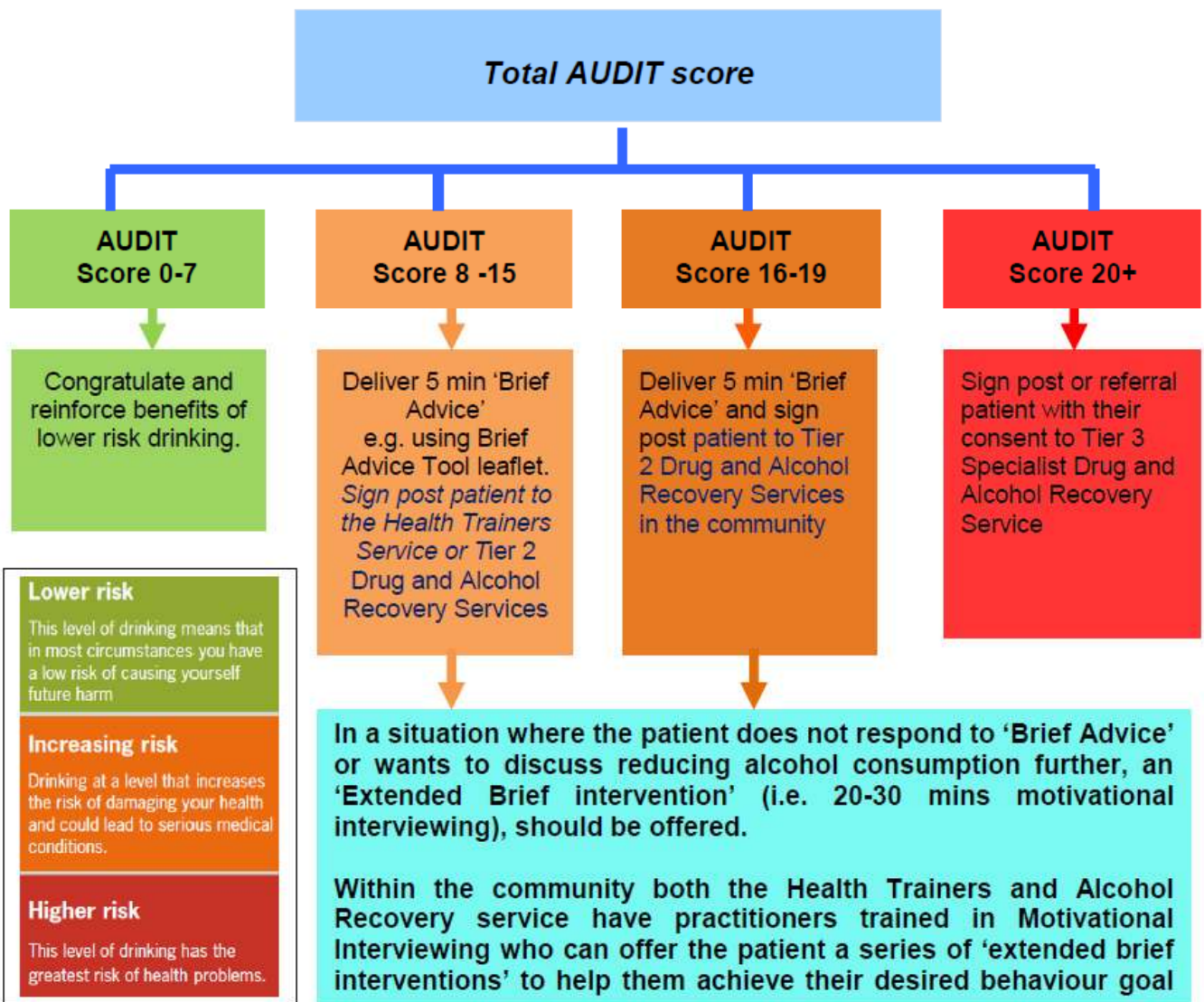
SCORING: ADD all ten scores together to identify necessary action (e.g. Brief Advice)

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 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



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)