Dr Rachel Charge & Dr Tatjana Djordjevic
North Kensington Medical Centre
St Quintin Avenue, London W10 6NX Tel: 020 8969 5151 Fax: 020 8960 6040
www.northkensingtonmedicalcentre.nhs.uk

Please complete all sections of the form

Full Name (capitals)		**Date of birth**	
Mobile Phone		**Home Phone**	
Email address			

If you happy for us to contact you by text please sign. (If the patient is 13 years or older – the form needs to be signed by the patient).	
Would you like to book appointments and request repeat prescriptions On-line? We will need to text your access details to you once we have created your medical record – so please make sure that you are happy with us doing this before you tick 'yes'(if the patient is 13 years or older – the form needs to be signed by the patient).	☐ Yes ☐ No

First Language		**Marital status**	

Improving access to the practice in relation to disability or sensory loss is important to us. Is you access restricted and what is the best form of communication for you?	☐ No ☐ Induction loop ☐ BSL sign language interpreter ☐ Disabled access ☐ Limited mobility ☐ Wheelchair access ☐ Guide dog access	☐ Interpreter (language) ☐ Information in an alternative format ☐ Palantypist or speech to text reporter ☐ Sight impaired ☐ Hearing impairment ☐ Has difficult with speech ☐ Other – write in below:
Allergies		

Are you a Carer?	☐ Yes ☐ No
If you are a carer please write in the name of the person you care for and your relationship to them.	
Patient Group **Would you like to help us to improve our services by joining our patient participation group?** **NKMC is committed to improving our services we provided to patients. To do this, it is vital we hear from people about their experiences, views and ideas for making our services better.** (If yes, please ensure you have provided your email address)	☐ Yes ☐ No

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Sharing your medical records with others

The NHS would like to share your data with others in a number of ways. Please answer the questions below so that we know how you wish us to share your data.

Summary care records (www.nhscarerecords.nhs.uk)

North Kensington Medical Centre is a part of the national Summary Care Record program. This enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS spine. The summary record can be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline.

Please indicate below whether you would like to have your own Summary Care Record by indicating your decision below.

☐ **Option 1**
I wish to have a Summary Care Record containing my medications allergies and adverse reactions or sensitivities to medications

☐ **Option 2**
I wish to have a Summary Care record with the above plus additional important medical information held on my record

☐ **Option 3**
I do not wish to have a Summary Care Record

Your ethnic background - please tick the appropriate box

☐ White British	☐ Black African	☐ Bangladeshi	☐ Chinese
☐ White Irish	☐ Black Caribbean	☐ Indian	Any other ethnic background – please state:
☐ White British mixed	☐ Black - any other black background	☐ Pakistani	
		☐ Any other Asian background	

Your next of kin details

Next of kin name (please write in capital letters)		**Next of kin/emergency contact details** (please write in capital letters)	
Title		**Address**	
First name			
Surname / family name		**Post code**	
		Telephone number/s	

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How is your next of kin related to you?			
Do you smoke? - please tick the appropriate boxes next to the options			
☐ I have never smoked	☐ I used to smoke	☐ I am a current smoker	☐ I am a current smoker and wish to stop smoking
	Quit Date:	How many/day?	Quit 51 (advice line) 0800 622 6988

How much alcohol do you drink?

(Please note - the scores are for internal use only)	**Score 0**	**Score 1**	**Score 2**	**Score 3**	**Score 4**
How often do you have a drink that contains alcohol?	**Never** ☐	**Monthly or less** ☐	**2 - 4 times per month** ☐	**2 - 3 times per week** ☐	**4 + times per week** ☐
How many standard alcoholic drinks do you have on a typical day when you are drinking?	**1 - 2** ☐	**3 - 4** ☐	**5 - 6** ☐	**7 - 9** ☐	**10 +** ☐
How often do you have 6 or more standard drinks on one occasion?	**Never** ☐	**Less than monthly** ☐	**Monthly** ☐	**Weekly** ☐	**Daily or almost daily** ☐

Medical Information

Please list your past medical history and any current repeat medications

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If aged between 25-64 yrs old, when did you last have your smear test? (female only)	
What was the result?	
Where was it done?	
What is your height	
What is your weight	
SIGNATURE	**DATE**