THIS FORM IS FOR **EXISTING PATIENTS** WHO HAVE NOW MOVED OUT OF THE PRACTICE CATCHMENT AREA.

IF YOU ARE UNSURE PLEASE CHECK THE WEBSITE BEFORE COMPLETING THIS FORM.

WESTBOURNE MEDICAL CENTRE

FORM ACCEPTED BY .....

DATE -FORM ACCEPTED .....

For QI Team:

REGISTERED GP .....

DATE- ENQUIRED WITH GP .....

GP's DECISION .....

OUT OF AREA– Change of Address Form

This is your application to become an Out of Area patient at Westbourne Medical Centre, before you complete this form please be aware we will NOT provide home visits and will assess if it is clinically appropriate and practical in each individual case to accept the registration.

It may take 14 days from the date we receive your paperwork to make a decision. We will confirm whether your application has been accepted to become an Out of Area Patient.

However, if your health needs change, we may review your registration at any point to see if it would be more appropriate for you to be registered with a GP Practice closer to your home address.

In case your registration application is not successful we advise that it's in your best interests to register with a practice closer to your home.

PLEASE SIGN BELOW TO CONFIRM YOU AGREE TO THESE CONDITIONS

Message to GP supporting your application (optional):

.....

.....

.....

Previous Details

First Name	.....
Surname	.....
Date of Birth	.....
Previous Address	.... Postcode .....

New Details

New Address	.... Postcode .....
Home Phone Number	.....
Mobile Number	.....
Email Address	.....

Change of Details for Children

1	**Child's Full Name**	.....	**Date of Birth**	.....
2	**Child's Full Name**	.....	**Date of Birth**	.....
3	**Child's Full Name**	.....	**Date of Birth**	.....
4	**Child's Full Name**	.....	**Date of Birth**	.....

I have read and agree to the conditions of Out of Area Registration and confirm that all above information is correct.

Signature:..... **Date:**.....

OUT OF AREA– Change of Address Form

The government has issued a directive to address the problem of illness associated with alcohol consumption.
To help in this initiative we can screen adults over 16 and assess the risk of drinking at hazardous/harmful levels.
This will enable the practice to provide a simple brief intervention where needed.

Please answer the following questions (Alcohol 'FAST' screening test)

How many units of alcohol do you drink per week?

……..……units/week

Scoring:	0	1	2	3	4	Totals:
How often do you have 8 units (Men) or 6 units (Women) or more on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
If you scored zero above, then FAST is negative and you may stop. If you scored 1-4 then carry on.						
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/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

Text Messaging:

I acknowledge that **appointment reminders** by text are an additional service, not under the control of the practice and that the practice cannot guarantee that a message will always be sent.
I understand that practice does not respond to replies on its SMS text service.
I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

I consent to the practice contacting me by text message for the purpose of reviews and appointments reminders: YES ☐ NO ☐

Other information:

Height ……

Weight ……

Are you a current smoker?	YES / NO
If YES, how many per day?	……
Would you like advice on giving up smoking?	YES / NO
If you no longer smoke, when did you stop?	……

Electronic Prescription Service (EPS):

Please nominate a pharmacy for us to send your prescriptions to electronically

……

……

……

Tick NO if you do not wish to use EPS NO ☐

Summary Care Record (SCR)

Please read YOUR SUMMARY CARE RECORD leaflet before signing this document

SCR– NHS SUMMARY CARE RECORD Please only tick ONE box

Express CONSENT for medication, allergies, adverse reactions only ☐

Express CONSENT for medication, allergies, adverse reactions and additional information ☐

Express DISSENT– Patient does NOT want a SCR and fully understands the risks involved with this decision ☐

Signature:…… **Date:**……