**GP services - Registration Form(Adult)**



The County Practice

Syston Health Centre

1330 Melton Road, Syston

Leicester, LE7 2EQ

Telephone: 0116 2950500

Fax: 0116 2950525

Thank you for applying to join (The County Practice). We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You may need to supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENSE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

**Fields marked with an asterix (\*) are mandatory.**

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| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First names |
| \*Any previous surname(s) (if applicable) | |  | \*Date of Birth **DD / MM / YYYY** |
| \*Male Female | |  | \*NHS No. |
| Town and country of birth | |  | \*Home address |
| \*Home telephone No. | |  |  |
| Work telephone No. | |  | \*Postcode |
| \*Mobile No. (if you have one) | |  | Email address |
| **Please help us trace your previous medical records by providing the following information** | | | |
| \*Previous address in the UK (if applicable) | |  | Name of previous doctor |
|  | |  | Address of previous doctor |
| Postcode | |  |  |

**If you are from abroad**

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| \*Your first UK address where you registered with a GP if you were previously living abroad |  | \*If previously a resident in the UK,  date of leaving |
|  |  | \*Date you first came to live in the UK (if applicable) |
| Postcode |  |  |

**If you are returning from the Armed Forces**

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| Address before enlisting |  | Service or Personnel No. |
|  |  | Enlistment date: |
| Postcode |  |  |

**Donor Registration Choices**

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| **NHS Organ Donor Registration**  “I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death”. Please tick the boxes that apply.  Any of my organs and tissue or…  Kidneys  Heart  Liver  Corneas  Lungs  Pancreas  Any part of my body  **For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23** |

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| **NHS Blood Donor Registration**  I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.  Yes I give consent to be included on the NHS Blood Donor Register  Tick here if you have given blood in the last 3 years  *For more information, please ask for the leaflet on joining the NHS Blood Donor Register My preferred address for donation is: (only if different from above, e.g. your place of work)*  **………………………………………………………………………………………………………………………………………….**, Postcode: **…………………………………………..** |

**Additional details about you**

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| What is your ethnic group?  **White**  British  Irish  Other White (please specify):  **Black**  Caribbean  African  Other Black (please specify):  **Asian**  Indian  Pakistani  Other Asian (please specify):  **Mixed**  White & Black Caribbean  White & African  White & Asian |

**Information and Communication Needs**

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| \*Do you have any communication or information needs due to disability, impairment or sensory loss? (if yes please specify) For further information please visit [**https://www.england.nhs.uk/ourwork/accessibleinfo/**](https://www.england.nhs.uk/ourwork/accessibleinfo/)  \*Communication or information method required i.e. braille; email |

**Carer/Next of Kin Relationship Information**

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| Do you have a Carer? Yes No Their contact details:  Do you consent for your carer to be informed about your medical care? Yes No |

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| Are you a Carer? Yes No  If yes, do you look after someone who is a patient of The County Practice? Yes No  Don’t know  If yes, what is their name? Are they a: Relative Friend Neighbour |

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| --- | --- | --- |
| Name of next of kin |  | Relationship to you |

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| --- | --- | --- |
| Next of kin telephone number(s) |  | Next of kin address (if different to above) |

**Looked after Children**

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| Are you looking after someone else’s child?  Yes  No  If Yes, under what arrangements:  Section 20-Voluntary Care  Interim Care Order  Care Order  Child arrangement order/Residence Order  Special Guardianship order Placed for adoption  Private arrangement/Private Fostering/informal arrangement  (please note you have a duty to notify social care of this arrangement) |

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| **In order to continue to receive your repeat medications you’ll need to make an appointment with a GP at least one week before your next prescription is due.** |

**Medical Details and Lifestyle Habits**

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| \*Are you allergic to any medicines?  Yes  No (if yes please specify) |

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| \*List other allergies (pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of |

**Have you ever had any of the following conditions?**

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| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | Yes | Year |  | **Rheumatoid Arthritis** | Yes | Year |
| **High Blood Pressure** | Yes | Year |  | **Mental Illness (Inc. Depression)** | Yes | Year |
| **Heart Attack** | Yes | Year |  | **Diabetes (type 1 or type 2)** | Yes | Year |
| **Angina (stable / unstable)** | Yes | Year |  | **Asthma** | Yes | Year |
| **Stroke** | Yes | Year |  | **COPD (or Emphysema)** | Yes | Year |
| **Transient Ischaemic Attack** | Yes | Year |  | **Osteoporosis / Bone Fractures** | Yes | Year |
| **Cancer** | Yes | Year |  | **Peripheral Vascular Disease** | Yes | Year |

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| List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place |

**Do you have family history of any of the following?**

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| **High Blood Pressure** | Yes | Who |  | **DVT / Pulmonary Embolism** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged >60 yrs. | Yes | Who |  | **Breast Cancer** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged <60 yrs. | Yes | Who |  | **Any Cancer**  Specify type: | Yes | Who |
| **Raised Cholesterol** | Yes | Who |  | **Thyroid disorder** | Yes | Who |
| **Stroke / CVA** | Yes | Who |  | **Epilepsy** | Yes | Who |
| **Asthma** | Yes | Who |  | **Osteoporosis** | Yes | Who |
| **Diabetes** | Yes | Who |  | **Other (Please list)** | | Who |

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| Height ft. in |  | (**for women only**) Have you had a cervical smear? Yes No  (*Please state where, when and the result if possible*) |
| Weight St. lb |
| Waist measurement in |

**Please tell us about your smoking habits**

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| Do you smoke?  Yes  No  If Yes, what do you primarily smoke:  Cigarettes / Cigar / Pipe / VAPE **(please circle)** |  | Are you an ex-smoker?  Yes  No  When did you quit?  How many did you used to smoke a day? |
| How many do you smoke a day?  Would you like advice on quitting?  Yes  No |  |

**Please tell us about your alcohol consumption**

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| --- | --- | --- | --- | --- | --- |
| **Questions** (please circle your answers in the boxes below) | **Unit scoring system** | | | | |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times  Per month | 2 - 4 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 |
| **Depending on your answers above you may be asked to complete an additional alcohol questionnaire.** | | | | | |
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**Communication Preferences**

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| \*Do you consent to receive the following types of communication from The County Practice?  **Mobile phone text messages** Yes No  **Answering machine messages** Yes No  **Letter** Yes No |

**GP Online Services – Patient Access Online**

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| Once your application to join our practice has been accepted you’ll be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **Patient Access**.  Once you are a fully registered patient of our practice you can visit [www.countypracticesyston.nhs.uk](http://www.countypracticesyston.nhs.uk) to begin your Patient Access registration. This service is available to everyone with a valid email address.  ***We can only accept your request for Patient Access if your email address is valid and not shared by another person.***  ***Would you like to use Patient Access?***  Yes  No  If yes, please specify the e-mail address you wish to use for GP Online access \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When your application to join the practice has been processed we will post to you your **Patient Access** details. |

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| **Summary Care Record (SCR)**  As you are registering with this practice, we would like to recommend that you take advantage of the Summary Care Record (SCR). It includes important information about your health: Medicines you are taking; allergies you suffer from, any bad reactions to medicines  **You can also choose** to have additional information included in your SCR, which can improve the care you receive. This information includes: Your illnesses and health problems; operations and vaccinations you have had in the past; how you would like to be treated – such as where you would prefer to receive care; what support you might need; who should be contacted for more information about you  You may need to be treated by health and care professionals outside of the practice who do not know your medical history. Having the additional information SCR can help the staff involved in your care access information more quickly, allowing them to make informed decisions about your healthcare. **More information can be found by visiting www.nhscarerecords.nhs.uk**  **Tick this box if you wish to opt-in to the Core SCR**  **Tick this box if you wish to opt-in to the Core an Additional SCR**  **Tick this box if you wish to opt-out of the SCR** |

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| **SUPPLEMENTARY QUESTIONS** | | | |
| **PATIENT DECLARATION for all patients who are not ordinarily resident in the UK** | | | |
| |  | | --- | | Anybody in England can register with a GP practice and receive free medical care from that practice.  However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK.  Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.  More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.  **You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.**  **The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.**  **Please tick one of the following boxes:**  a)  I understand that I may need to pay for NHS treatment outside of the GP practice  b)  I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the Surcharge”), when accompanied by a valid visa. I can provide documents to support this when requested  c)  I do not know my chargeable status  I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.  **A parent/guardian should complete the form on behalf of a child under 16.** | | | | |
| **\*Signed:** |  | **\*Date:** | **DD / MM / YYYY** |
| **\*Print name:** |  | **\*Relationship**  **to patient:** |  |
| **\*On behalf of:** |  |

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| **Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.** | | | |
| **NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC)DETAILS and S1 FORMS** | | | |
| **Do you have a non-UK EHIC or PRC?** | Yes  No | **If yes, please enter details from your EHIC or PRC below:** | |
| *If you are visiting from another EEA*  *Country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.* | **Country Code:** |  | |
| **3: Name** |  | |
| **4: Given Names** |  | |
| **5: Date of Birth** | **DD / MM / YYYY** | |
| **6: Personal Identification**  **Number** |  | |
| **7: Identification number**  **of the institution** |  | |
| **8: Identification number of the card** |  | |
| **9: Expiry Date** | **DD / MM / YYYY** | |
| **PRC validity period (a) From:** | **DD / MM / YYYY** | **(b) To:** | **DD / MM / YYYY** |
| Please tick  if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.** | | | |

**Once you are registered…**

New Patient Health-check

If there are any problems with your registration we’ll contact you to clarify any issues, but once your details have been entered into our computerised records you will be eligible for a new patient health-check with a Health Care Assistant.  You will receive a letter from the practice offering you an appointment.

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| **Please record any additional information about you that you think is important for us to know** |

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| **\*Signed** |  | **\*Date DD / MM / YYYY** |

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| **\*Signed on behalf of patient** (*if applicable*)  (e.g. for minors under 16 years old, adults lacking capacity) |  |
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| **FOR OFFICE USE ONLY**  **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Initials: \_\_\_\_\_\_\_\_\_\_** |
| **PHOTO ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Aged 16 and over only) |