ADULT REGISTRATION FORM

THIS PAGE IS FOR OFFICE USE ONLY

ADMIN CHECKLIST:

- ☐ Date stamped form
- ☐ Have all areas of the form been completed by the patient?
- ☐ Have they provided proof of ID and proof of address?
- ☐ Have you informed the patient that they need to ensure their current Practice has issued them with 1 month's supply of any medication to cover them for the registration period?
- ☐ Have you asked the patient if they would like to be signed up for System online? If yes, ensure they have completed the box on page 6.
- ☐ Have you asked the patient if they would like to nominate a pharmacy? If so, please ensure they have filled out the relevant box on page 6
- ☐ Have you ensured the patient understand our prescription time process is 48 hours for repeat medication?

FOR OFFICE USE ONLY
Date:_____

Staff Initials: _____

PHOTO ID☐ **TYPE:** _____

ADDRESS ID☐ **TYPE:** _____
(Aged 16 and over only)

GP services - Registration Form(Adult)

Central Surgery
Brooksby Drive
Oadby
Leicester
LE2 5AA
Tel: 0116 271 2175
https://thecentralsurgeryoadby.co.uk

Thank you for applying to join *Central Surgery - Oadby*.
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.

*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 *Postcode
*Home telephone No.	
Work telephone No.	
*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) Postcode	Name of previous doctor Address of previous doctor

If you are from abroad

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

If you are returning from the Armed Forces

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

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

Donor Registration Choices

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 ☐

Additional details about you

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

Main spoken language (E.g. English):

Information and Communication Needs

*Do you have any communication or information needs due to disability, impairment or sensory loss? (if yes please specify)

*Communication or information method required i.e. braille; email

<u>The Accessible Information Standard (AIS)</u>
Please use this space to tell us about any specific communication needs you have. I.e. needing information in large print or deafblind telephone contact. For further information please visit https://www.england.nhs.uk/ourwork/accessibleinfo

Carer Relationship Information
A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

Are you looked after by someone whose support you could not manage without? ☐Yes ☐No
If yes, what is their name, contact number and relationship to you?

In accordance with the General Data Protection Regulation, the practice needs your consent if you would like someone to act on your behalf to discuss your results, prescriptions or medical care and information. Please note that by giving consent you will be giving authority for us to share your medical information with the person named below. This consent will remain in place unless withdrawn in writing by you.

I give consent for _____ to discuss test results / discuss medical information / appointment information / collect prescriptions on my behalf (Delete as appropriate)

(Please note that we are unable to hand out prescriptions to anyone under the age of 18)

Signed: _____ Date: _____

Next of Kin Relationship Information

Name of next of kin	Relationship to you
Next of kin telephone number(s)	**Next of kin address (if different to above)**

Do you look after or support someone who couldn't manage without you? ☐Yes ☐No

If yes, is that person a patient of Central Surgery? ☐Yes ☐No ☐Don't know
If yes, what is their name:

Are they a ☐Friend ☐Relative ☐Neighbour
We would like to support you with your caring responsibilities, please ask at reception for a copy of our carers pack.

Looked after Children

*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)

Medical Details and Lifestyle Habits

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

*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?

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

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?

High Blood Pressure	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs.	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs.	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who
Stroke / CVA	☐ Yes	Who
Asthma	☐ Yes	Who
Diabetes	☐ Yes	Who

DVT / Pulmonary Embolism	☐ Yes	Who
Breast Cancer	☐ Yes	Who
Any Cancer Specify type:	☐ Yes	Who
Thyroid disorder	☐ Yes	Who
Epilepsy	☐ Yes	Who
Osteoporosis	☐ Yes	Who
Other (Please list)		Who

Height	ft.	in
Weight	St.	lb
Waist measurement	in	

(F**or women only**) Have you had a cervical smear?
☐Yes ☐No
(*Please state where, when and the result if possible*)

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No If Yes, what do you primarily smoke: Cigarettes / Cigar / Pipe / VAPE **(please circle)**
How many do you smoke a day? Would you like advice on quitting? ☐ Yes ☐ No

Are you an ex-smoker? ☐ Yes ☐ No

When did you quit?

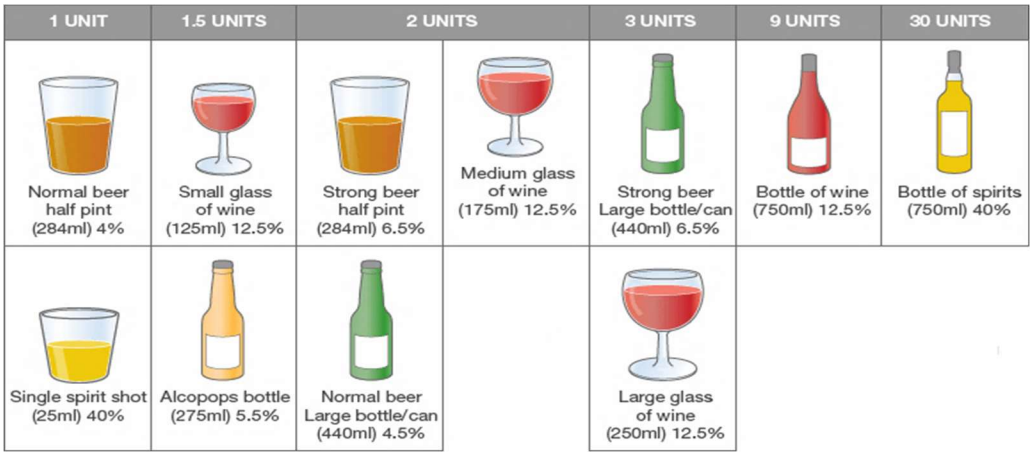
How many did you used to smoke a day?

Please tell us about your alcohol consumption

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	2 - 4 times per	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.



Communication Preferences

*Do you consent to receive the following types of communication from *Central Surgery – Oadby*?

Email ☐Yes ☐No

Mobile phone text messages ☐Yes ☐No

Answering machine messages ☐Yes ☐No

Letter ☐Yes ☐No

GP Online Services – Patient Online Access

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 *https://thecentralsurgeryoadby.co.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

We have two online services:

Systmonline – Where you can order prescriptions & view part of your medical record online

If yes, please specify the e-mail address you wish to use for GP Online access

_____

Electronic prescribing service (EPS)

You will be able to nominate a pharmacy to collect your prescriptions, EPS enables prescribers, such as GP's and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen.

I would like my prescription sent electronically to:……..

Data Sharing

Electronic Data Sharing Module (EDSM)
Healthcare places can usually share information from your records by letter, email, fax or phone but this can slow down your treatment or mean information is hard to access. However, you can choose to share your record electronically between care services. **For more information please visit our website at** *https://thecentralsurgeryoadby.co.uk*

Tick this box if you wish to opt-in to the EDSM ☐

Tick this box if you wish to opt-out to the EDSM ☐

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 ☐

National Data Opt out
Your health records contain a type of data called confidential patient information. The NHS can use this data to help with research and planning. You can choose to stop your confidential patient information being used for research and planning. You can also make a choice for someone else like your children under the age of 13. Your choice will only apply to the health and care system in England.

To register your preference go to https://your-data-matters.service.nhs.uk/

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. 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:**			

Once you are registered…

Once we have received your completed form you will be registered within 28 days

If there are any problems with your registration we'll contact you to clarify any issues.

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

***Signed**	***Date** DD / MM / YYYY

***Signed on behalf of patient** (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)