

CHARNWOOD SURGERY

ADULT

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NEW PATIENT REGISTRATION INFORMATION SHEET



Thank you for your enquiry to register with Charnwood Surgery. It is at the Senior GPs discretion to accept you onto our Patient register.

REGISTRATION PROCESS

Patients wishing to register with the practice will need to demonstrate that they are entitled to free NHS treatment by completing a GMS1 form, health questionnaire and a smoking questionnaire.

The Practice will need to establish that you have a main residence in the practice area. Dependants of patients who fulfil the criteria are also entitled to free treatment as long as they are the spouse (including civil partner), or a child, and are living together at the same address.

Entitlement to free NHS treatment is on the basis of **residency** regardless of any previous national insurance or tax contributions and irrespective of whether you are a UK passport holder. Holding an NHS number does not indicate that the NHS treatment is free of charge. **Proof of identity and address are required (see below).**

UK citizens living abroad

If you live abroad for most of the year you are not entitled to continue to be registered with this practice. Anyone leaving the UK with the intention of living abroad for a period of 90 days or longer must notify the practice of this in advance. If you fall ill when returning on a visit, you are entitled to emergency care, if this is deemed necessary by the practice.

The onus is on the patient to prove their eligibility

All patients requesting to register with the Practice need to produce two forms of ID:

- **Photo ID** – current valid signed passport, Current UK driving licence or current EU/EAA driving licence, EU identification card
- **Address ID** – Utility bill, rental agreement, bank statement (no older than 3 months), mortgage statement, solicitors letter confirming recent purchase of property

Children under 16 whose parent/guardian is registered with the practice/registering at the same time will need to provide either an original birth certificate or a certified copy or a valid passport.

(patients need to be informed that photocopies will be taken and this information will then be scanned onto their medical records for proof of identity purposes)

If a patient repeatedly fails or refuses to provide identification or if staff have concerns over any patient (identified or otherwise), they may contact the Local Counter Fraud Specialist (LCFS). Contacting the LCFS does not breach the Data Protection Act: section 29 (3) which allows for the release of information for the prevention and detection of crime.

Thank you for applying to join Charnwood Surgery. 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. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.
Fields marked with an asterix (*) are mandatory.

*Title	*Surname
*Any previous surname(s)	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
Town and country of birth	
Home telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Work telephone No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile No.	Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No

*First names
*Date of Birth
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address & Postcode
*Previous address & Postcode
Email address

*Previous GP Details
(for women only) Have you had a cervical smear? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please state where, when and the result if possible)</i>

If you are from abroad please tell us your first UK address where registered with a GP:
If previously resident in UK, date of leaving:
Date you first came to live in UK:
Marital Status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Additional details about you

What is your ethnic group?			
White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	
Black	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	
Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese
Mixed	<input type="checkbox"/> White + Black Caribbean	<input type="checkbox"/> White + African	<input type="checkbox"/> White + Asian
Other	<input type="checkbox"/> Please specify:		

Main Language Spoken? (E.g. English)

Have you ever been in the employ of the Armed Forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Personnel Number:</i>	<i>Date Enlisted:</i>
<i>Date Left:</i>	
Are you a dependant of a current serving member of British Armed Forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Next of kin \ Emergency contact

Name of next of kin \ Emergency contact
Next of kin \ Emergency contact telephone number(s)

Relationship to you
Next of kin \ Emergency contact address (if different to above)

Data Sharing

Summary Care Record (SCR)

Your SCR is an electronic summary of key medical information taken from your GP medical record. If you need healthcare away from your usual doctor's surgery, your enhanced SCR will provide those looking after you with key information to help them give you better and quicker care. Please refer to 'What is a Summary Care Record' document for more information or visit: <https://digital.nhs.uk/summary-care-records/patients>

Tick this box if you wish to have an enhanced SCR with core and additional information (recommended)

Tick this box if you wish to opt-out of the SCR

Medical Interoperability Gateway (MIG)

The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care you will be asked if you consent to the care service seeing essential elements of your record.

More information can be found by visiting: <http://www.healthcaregateway.co.uk/products>

Tick this box if you wish to opt-out of the MIG data sharing

Risk Stratification Preferences

Risk stratification is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Charnwood Surgery is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.

For more information please visit our website at www.hiranicharnwoodsurgery.co.uk

Tick this box if you wish to opt-out of the Risk Stratification programme

Enhanced Data Sharing Module (EDSM)

Charnwood Surgery use a clinical computer system called SystemOne to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use SystemOne.

These other services will always ask consent to view your record. For more information please visit our website at www.hiranicharnwoodsurgery.co.uk

Tick this box if you wish to opt-out of the Enhanced Data Sharing Module

*Do you consent to receive the following types of communication (if offered) from Charnwood Surgery?

Email Yes No

Mobile phone text messages Yes No

Answering machine messages Yes No

Carers Information

A carer is a friend or 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 who's support you could not manage without? Yes No

If yes, what is their name and contact number?

Do you consent for your carer to be informed about your medical care? Yes No

Do you look after or support someone who couldn't manage without you? Yes No **If yes, please ask at reception about Carers Support**

If yes, do you look after someone who is a patient of Charnwood Surgery? Yes No Don't know

If yes, what is their name?

Are they a: Relative Friend Neighbour

Medical details

In order to continue to receive your repeat medications you'll need to make a new patient health check appointment and bring in your last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with your repeat medication list found on the right hand side or a printed prescription.

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

*List other allergies / intolerances (i.e. nuts, gluten, 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	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack / Angina	<input type="checkbox"/> Yes	Year
Stroke / Mini-stroke (TIA)	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year
Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year

Mental Illness	<input type="checkbox"/> Yes	Year
Diabetes	<input type="checkbox"/> Yes	Year
Asthma	<input type="checkbox"/> Yes	Year
COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Osteoporosis / Bone fractures	<input type="checkbox"/> Yes	Year
Peripheral vascular disease	<input type="checkbox"/> Yes	Year

Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs.

The Accessible Information Standard (AIS)

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/>

Do you have family history of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who

DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Breast Cancer	<input type="checkbox"/> Yes	Who
Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Thyroid disorder	<input type="checkbox"/> Yes	Who
Epilepsy	<input type="checkbox"/> Yes	Who
Osteoporosis	<input type="checkbox"/> Yes	Who

Please tell us about your smoking habits

Do you smoke? Yes No

If Yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe (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)	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.

1 UNIT	1.5 UNITS	2 UNITS	3 UNITS	9 UNITS	30 UNITS	
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Medium glass of wine (175ml) 12.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%	 Large glass of wine (250ml) 12.5%			

Do you exercise regularly? Yes No

If so – What exercise do you take?

How often?

*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.

I give consent for _____ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

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

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: _____

Date: _____

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

Electronic Prescription Service (EPS)

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as 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. **For further information about this service, please talk to your pharmacist of choice, or nominate a pharmacy of your choice below.**

Patient Participation / Reference Group (PPG) (PRG) or Virtual Group.

If you would like more information, please ask at Reception.

***Signed**

***Date**

/ / /

Signed on behalf of patient *(if applicable)*

(e.g. for minors under 16 years old, adults lacking capacity)

On-line Services

You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet. See separate sheet attached for details.

Once you are registered...

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 computerized records...

New Patient Health-check

You will be eligible for a new patient health-check with a Practice Nurse.

Would you like to have a new patient health check? Yes No

If yes, a receptionist will contact you to arrange a convenient appointment.

FOR OFFICE USE ONLY

PHOTO ID

TYPE: _____

(Over 18 only)

ADDRESS ID

TYPE: _____

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Online Services – Charnwood Surgery offers Internet facilities for booking GP appointments, ordering repeat medication and accessing your summary medical record online. You need to be registered in order to access this service. You can *only* apply for yourself and must be aged 16 and over. If under the age of 16, then parental consent must be obtained. Do you want to be registered for the online services?

Yes No If yes, sign the declaration below

If you wish to have access to your detailed coded medical please ask the reception for the appropriate form.

Declaration: Please supply me with my User Name and Password details to allow me to access the online appointment booking and repeat medication ordering services. I understand that I am responsible for securing these details to prevent unauthorised persons from accessing my record on line. In the event that my security details have been compromised I will inform the Practice immediately so that access can be blocked and a new password issued. If at any time I wish to permanently cease Internet access I will inform the practice in writing. I confirm that I have read these terms and conditions and agree to them.

Signature Patient/Parent/Guardian

Email:

Date