GP Services – Patient Registration Form (Adult)

Aylestone Health Centre
15 Hall Lane
Leicester
LE2 8SF
0116 283 7825
https://www.aylestonehealthcentre.co.uk/

Thank you for applying to join Aylestone Health Centre. 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 every question but what you do fill in will help us to 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 asterisk (*) are mandatory.

***Title** ***Surname**	**Referred by a GP Registration Officer** ☐ **Ukraine Settlement Scheme** ☐
***First names**	***NHS No.** ☐☐☐☐☐☐☐☐☐☐
***Any previous surname(s) (if applicable)**	***Date of Birth** DD / MM / YYYY
*☐ **Male** ☐ **Female** ☐ **Other:**	***Home address**
Town and country of birth	***Postcode**
***Preferred Contact No.**	**E-mail address**
Work telephone No.	

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** ***Postcode**	***If previously a resident in the UK, date of leaving:** DD / MM / YYYY ***Date you first came to live in the UK (if applicable):** DD / MM / YYYY

If you are returning from the Armed Forces

***Address before enlisting** ***Postcode**	**Service or Personnel No.** **Enlistment date:** DD / MM / YYYY

*If you need your doctor to dispense medications and appliances**

I live more than 1.6 km in a straight line from the nearest chemist ☐
I would have serious difficulty in getting them from a chemist ☐
*Not all doctors are authorised to dispense medicines

Signature of Patient ☐ **Signature on Behalf of Patient** ☐

_____

Date: DD / MM / YYYY

Next of kin information

Please note the details about yourself

***Name of next of kin: _____**	**Main Spoken Language : _____**
***Relationship to you:_____**	**Occupation : _____**
***Telephone number(s):_____**	**Religion : _____**
***Address:_____**	**Marital Status : _____**

Additional details about you

***What is your ethnic group?**

White: British ☐ White: Irish ☐ Gypsy/ Irish Traveller ☐ Other White ☐ Black: African ☐ Black: Caribbean ☐

Other Black ☐ Asian: Bangladeshi ☐ Asian: Chinese ☐ Pakistani ☐ Indian ☐ Other Asian ☐ Arab ☐

Mixed: White & Asian ☐ Mixed: White & Black African ☐ Mixed: White & Black Caribbean ☐ Mixed: Other ☐

I do not wish to state my ethnicity ☐

Which of the following best describes you? (tick the appropriate)
Bisexual
Male homosexual
Female homosexual
Heterosexual
Transgender gender reassignment patient
Transgender gender identity disorder

Reasonable Adjustments

Do you have a Disability: - YES_____ / NO_____

***Do you have a communication need that is related to your disability? YES____/ NO____**

If you have answered YES, please tell us what communication need you have: TICK THE APPROPRIATE:

Use hearing loop	**Use lip speaker**	**Use hearing aid**
Use British Sign Language	**Use cued speech cued transliterator**	**Use alternative communication skill**
Use Makaton Sign Language	**Use deaf-blind intervener**	**Use sign language**
Use text phone	**Use communication device**	**Use manual note taker**
Use speech to text reporter	**Personal Communication Passport**	
Other		

- **Do you require information in a preferred format: YES ____/ NO_____**

If you have another communication need, please specify: (TICK THE APPROPRIATE)

Require contact by telephone	**Require contact by email**	**Require contact by text relay**
Require contact by letter	**Require information in Makaton**	**Require information in braille**
Require information in large font	**Require information in EASYREAD**	**Medicine labelling large print**
Require audible alert	**Require visual alert**	**Require tactile alert**
Require communication partner	**Deafblind communication guide**	**Face the client communication**
Interpreter needed- BSL	**Deafblind telephone user**	**Other:**

Carer information

Do you have a carer? ☐Yes ☐No

Their contact number:

If yes, do you consent for your carer to be informed of your medical care? ☐Yes ☐No

If yes, what level of access to you wish to grant them?

☐ Full record ☐ Medication & Appointments only

☐Other (Please Specify):

Are you a carer? ☐Yes ☐No

If yes, do you look after someone who is a patient of Aylestone Health Centre?

☐Yes ☐No ☐Don't know

If yes, what is their name?

Relationship to you: ☐ Relative ☐ Friend ☐ Neighbour

Patient Record Sharing

Summary Care Record (SCR)

All patients registered with a GP have a Summary Care Record unless they have chosen not to have one. The information held in a Summary Care Record gives health and care professionals, away from their usual GP practice, access to information to provide them with safer care, reduce the risk of prescribing errors and improve their patient experience. **More information can be found by visiting, https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients**

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

Electronic Data Sharing Module (EDSM)

LLR services use the SystmOne record system to share information with each other

Tick this box if you wish to <u>opt-in</u> to the EDSM ☐
Tick this box if you wish to <u>opt-out</u> to the 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://www.aylestonehealthcentre.co.uk/*

LLR Care Record

The LLR Care Record (LLRCR), part of the national Shared Care Records (ShCR) programme, will bring together a person's separate records into a structured, easy-to-read format. This will give health and care professionals directly involved in an individual's care, a more complete view of the care and treatment that they have received across all services. It will mean information recorded about someone's health and care such as illnesses, treatments and hospital admissions can be accessed by different people who are involved in their care.

Opting Out

Health and social care professionals can inform patients how their information is shared and tell them how they can object if they want to. Objecting will not affect their treatment, but the LLR Care Record will make information sharing quicker, easier, and more complete, which helps to get the right treatment at the right time, especially in an emergency situation.
Patients will need to register their wish to object with the information governance lead at the relevant health and care organisation they are receiving care from. **More details about patients' information rights can be found by visiting**

https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/02/LLR-Objecting-to-inclusion-A4.pdf

Have you had any of the following conditions?

Angina (stable/unstable)	☐	**Year**
Asthma	☐	**Year**
Atrial fibrillation	☐	**Year**
COPD (or Emphysema)	☐	**Year**
Cancer	☐	**Year**
Chronic kidney disease (CKD)	☐	**Year**
Dementia	☐	**Year**
Depression	☐	**Year**

Diabetes	☐	**Year**
Epilepsy	☐	**Year**
High blood pressure	☐	**Year**
Heart attack	☐	**Year**
Heart failure	☐	**Year**
Learning disabilities	☐	**Year**
Mental health	☐	**Year**
Non-diabetic hypoglycaemia	☐	**Year**

Obesity	☐	**Year**
Osteoporosis	☐	**Year**
Peripheral Arterial Disease	☐	**Year**
Rheumatoid Arthritis	☐	**Year**
Stroke	☐	**Year**
Transient Ischaemic Attack	☐	**Year**

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

Do you have any family history of the following?

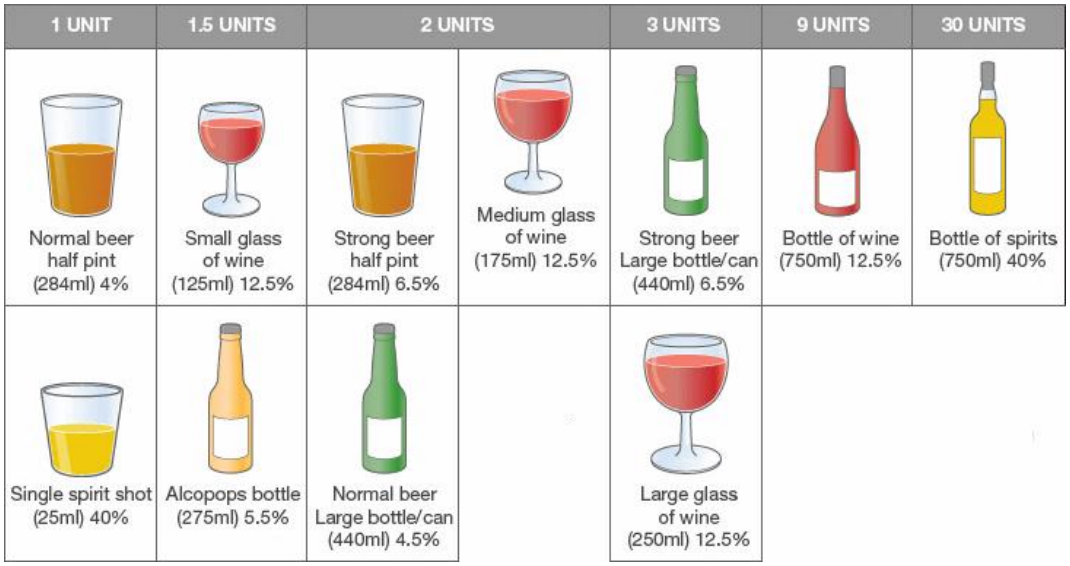
High blood pressure	☐	**Who**
Ischaemic heart disease Diagnosed aged >60 years	☐	**Who**
Ischaemic heart disease Diagnosed aged <60 years	☐	**Who**
Raise cholesterol	☐	**Who**
Stroke/CVA	☐	**Who**
Breast Cancer	☐	**Who**
Any Cancer (please specify)	☐	**Who**

DVT/Pulmonary embolism	☐	**Who**
Asthma	☐	**Who**
Diabetes (please specify type)	☐	**Who**
Thyroid disorder	☐	**Who**
Epilepsy	☐	**Who**
Osteoporosis	☐	**Who**
Other (please specify)		**Who**

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 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.



Smoking Habits

Do you smoke? ☐Yes ☐No
If yes, what do you primarily smoke?
Cigarettes / Cigar / Pipe / Vape

How many cigarettes do you smoke per day?

Would you like advice on quitting? ☐Yes ☐No

Are you an ex-smoker? ☐Yes ☐No

When did you quit?

How many cigarettes did you smoke per day?

Height and Weight

Height **ft.** **in.**

Weight **st.** **lb.**

Waist Measurement **in.**

Do you exercise regularly?
☐ None
☐ Some
☐ 3 times a week
☐ 4 times a week
☐ Competitive athlete

(For Women Only)

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

Medical details and lifestyle habits

***Are you currently on any repeat medication?** ☐Yes ☐No If yes, please state**:**	***Are you allergic to any medicines?** ☐Yes ☐No If yes, please state**:**
***Which pharmacy would you like your medication to go to?**	***List any other allergies** (e.g., pollen, animal hair or certain foods**):**

Communication Preferences

***Do you consent to receive the following types of communication from the practice?**		
E-mail*: ☐ Yes ☐ No	**Text Message*:** ☐ Yes ☐ No	**Answering machine*:** ☐ Yes ☐ No

GP Online Services – Patient Online Proxy 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 using GP Online Services. This service is known as **SystmOnline**.

Once you are a fully registered patient of our practice you can visit *https://www.aylestonehealthcentre.co.uk/* to begin your **SystmOnline** registration. This service is available to everyone with a valid email address. ***We can only accept your request for SystmOnline if your email address is valid and not shared by another person.***

Would you like to use SystmOnline? ☐ 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 text to you your **SystmOnline** details.

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:	

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:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD / MM / YYYY
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.	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.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Consent to Information Sharing Agreement

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.

NAME: _____ DOB_____

PLEASE NOMINATE A PHARMACY WHERE WE CAN SEND YOUR MEDICATION TOO.

……

I give consent for: _____ to collect prescriptions on my behalf. (please note we are unable to give prescriptions to anyone under the age of 15)

I give consent for: _____ to obtain test results / medical information / appointment information on my behalf.

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

***Signed:**
***Signed on behalf of patient** (*if applicable*)**:** (e.g. for adults lacking capacity)
***Date:**

TO BE COMPLETED BY THE GP PRACTICE

I have accepted this patient for general medical services on behalf of the practice

I will dispense medical/appliances to this patient subject to NHS England approval

Staff Signature: **Date:** DD / MM / YYYY

Practice Stamp

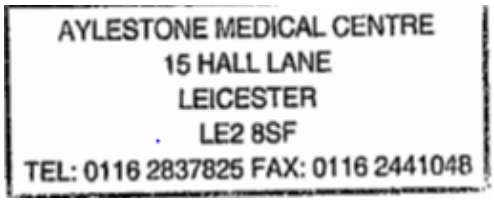


PHOTO ID: ☐ **TYPE:** **ADDRESS ID:** ☐ **TYPE:**
(Aged 16 and over only)