NHS and Private Medical Services
St Peters Health Centre
Sparkenhoe St
Leicester
LE2 0TA
Tel: 0116 2957835
Fax: 0116 2957836

Shefa Medical Practice

GP services - Registration Form(Adult)

Thank you for applying to join SHEFA MEDICAL PRACTICE. We would like to gather some information about you and ask that you fill in the following questionnaire. **You will 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
*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) 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:

Donor Registration Choices

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

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

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

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

☐Yes ☐No

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

First Language ……

Second Language ……..

Carer/Next of Kin Relationship Information

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

Are you a Carer? ☐Yes ☐No

If yes, do you look after someone who is a patient of SHEFA MEDICAL PRACTICE? ☐Yes ☐No ☐ Don't know

If yes, what is their name? Are they a: ☐Relative ☐Friend ☐Neighbour

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

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

*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	**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

Height	ft.	in
Weight	St.	lb
Waist measurement	in	

(**for 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

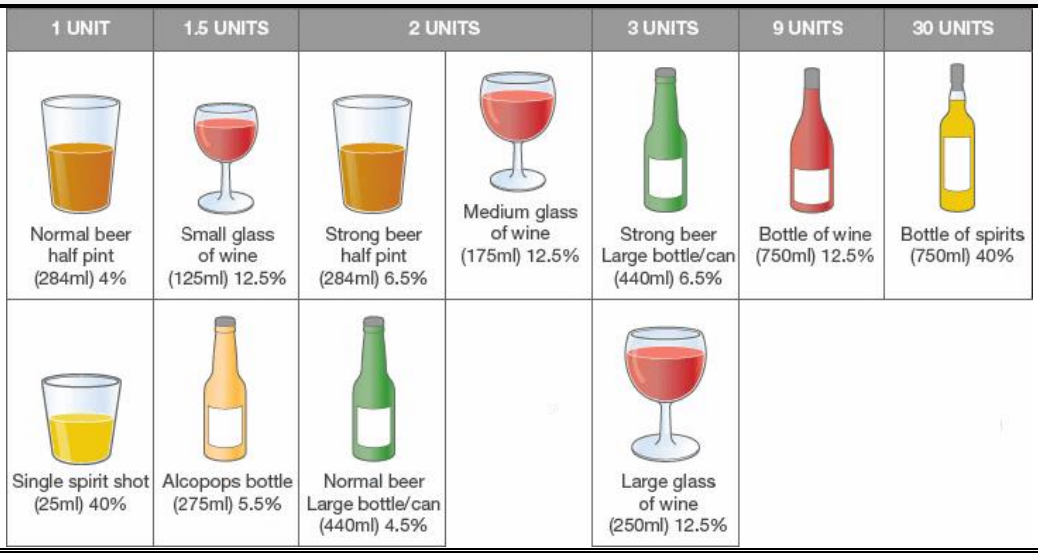
When did you quit?

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 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.



Communication Preferences

*Do you consent to receive the following types of communication from SHEFA MEDICAL PRACTICE?

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, we can register you for Patient Access Online.

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 Send you Text Message OR post to you your **Patient Access** details.

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 www.shefamedicalpractice.co.uk**

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

NO - 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**

YES - Tick this box if you wish to opt-in to the Core an Additional SCR ☐

YES - Tick this box if you wish to opt-in to the Core SCR ☐

NO - Tick this box if you wish to opt-out of the SCR ☐

Medical Interoperability Gateway (MIG)

Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.
For more information please visit the Sharing Your Medical Record page on our website at www.shefamedicalpractice.co.uk

YES - Tick this box if you wish to opt-in of the MIG ☐
NO - Tick this box if you wish to opt-out of the MIG ☐

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:**
 *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.**

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.

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. Contact reception if you should like to take this up.

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)

FOR OFFICE USE ONLY
Date:_____ **Staff Initials:** _____

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