Emis No.:

Billesdon Surgery

4 Market Place, Billesdon, Leicester, LE7 9AJ
Tel: 0116 2596206, Web: www.billesdonsurgery.co.uk

Thank you for applying to join Billesdon 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. **You must supply IN PERSON 2 forms of Identification with your completed form, a photographic 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.

*****YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION*****

*Title: *Surname:	*First names:
*Any previous surname(s) (if applicable):	*Date of Birth:
*☐Male ☐Female ☐Intermediate ☐Unspecified	*NHS No. ☐☐☐☐☐☐☐☐☐☐
*Town and country of birth:	*Home address & Postcode:
*Home telephone No.:	*Previous address & Postcode:
Work telephone No.:	
*Mobile No. (if you have one):	Email address:

*Previous GP Details (name and address):	***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 the UK:**

Tick this box if you have you ever been in the employ of the Armed Forces ☐
Personnel number: Date enlisted: Date left the armed forces:
Tick this box if you are a dependant of a current serving member of the British Armed Forces ☐

Additional details about you

What is your ethnic group? **Main spoken language (E.g. English):**

White	☐ British	☐ Irish	☐ Other White (please specify):		
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):		
Asian	☐ Indian	☐ Pakistani	☐ Chinese	☐ Other Asian (please specify):	
Mixed	☐ White + Black Caribbean		☐ White + African	☐ White + Asian	☐ Other mixed:

Height	_____ Feet	_____ Inches
Weight	_____ Stone	_____ Pounds
Waist measurement		_____ Inches

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

Next Of Kin / Emergency contact

1 Name / Relationship to you / Telephone No. / Address (if different to yours)

2 Name / Relationship to you / Telephone No. / Address (if different to yours)

Carers 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 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, do you look after someone who is a patient of Billesdon Surgery? ☐ Yes ☐ No ☐ Don't know

If yes, what is their name:

Are they a ☐ Friend ☐ Relative ☐ Neighbour

Medical details

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.

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

*List other allergies / intolerances (i.e 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	**Mental Illness (inc Depression)**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Diabetes (type 1 or type 2)**	☐ Yes	Year
Heart Attack / Angina	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke / Mini-Stroke (TIA)	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Cancer	☐ Yes	Year	**Osteoporosis / Bone Fractures**	☐ Yes	Year
Rheumatoid Arthritis	☐ 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 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:

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

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

1 Unit = Normal half pint beer (284ml) 4% *or* Single shot spirit (25ml) 40%. **1.5 Units** = Small glass of wine (125ml) 12.5% *or* Alcopop (275ml) 5.5%.
2 Units = Strong half pint beer (284ml) 6.5% *or* Medium glass of wine (175ml) 12.5% *or* Normal large bottle/can beer (440ml) 4.5%
3 Units = Strong bottle/can beer (440ml) 6.5% *or* Bottle of wine (750ml) 12.5% *or* Bottle spirits (750ml) 40% *or* Large glass of wine (250ml) 12.5%

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
IF YOU SCORE A TOTAL OF 5 OR MORE ON THE ABOVE QUESTIONS, PLEASE COMPLETE THE FURTHER 7 QUESTIONS BELOW					
How often in the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes but not in the last year		Yes during the last year

Your total score for *all ten* questions indicates the following:
0-7 = sensible drinking 8-15 = hazardous drinking
16-19 = harmful drinking 20+ = possible dependence

Would you like information or advice about alcohol consumption? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, what exercise do you take and how often:

Data Sharing

We may want to contact you by email, send appointment reminders to your mobile and leave messages on your answering machine, if you have one. **Tick these boxes if you do not wish to be contacted in this way: Email ☐ SMS ☐ Answering machine ☐**

Summary Care Record (SCR)
Your SCR is an electronic summary of key medical information taken from your 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. **For more information visit: http://systems.digital.nhs.uk/scr**

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

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

Medical Interoperability Gateway (MIG)
Whilst the SCR 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 visit:**
http://www.healthcaregateway.co.uk/products

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

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

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

Looked after Children *(Complete this section only if you are looking after someone else's child)*

Under what arrangements are you looking after someone else's child?

☐ 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 (*please note you have a duty to notify social care of this arrangement*)

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/**

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: _____

Online Patient 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 **Online Patient Access**. To register for this service either visit our website **www.billesdonsurgery.co.uk** or ask reception for an **application form**. You'll need to bring your completed form to reception with **two forms of ID** (under 16 year olds are exempt from ID). You'll be emailed a PIN letter within **seven working days**. You'll use this PIN letter to create your online account. Please note ***you must have an email address to use this service* and consent to receiving emails from Billesdon Surgery**. Full terms and conditions are available on the application form.

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/Health Care Assistant. Contact reception if you should like to take this up.

Electronic Prescription Service (EPS)

… you will be able to nominate a pharmacy to collect your prescriptions from. 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. For further information about this service please talk to your pharmacist of choice.

Please record any additional information about you that you think is important for us to know on a separate sheet of paper and attached to this registration form.

***Signed** ***Date / / /**

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

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE:** _____ **ADDRESS ID** ☐ **TYPE:** _____
(Aged 18 and over only)

ID exempt (returning university students only) ☐

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS Enhanced Summary Care Record with additional information

If you are registered with a GP practice in England you will have a core Summary Care Record (SCR), unless you have previously chosen not to have one. 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 enhance 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

Healthcare leads across LLR recommend that all patients sign up. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an enhanced SCR can help the staff involved in your care access information more quickly, enabling them to make better and safer decisions about your treatment.

What to do next

If you would like your SCR to be enhanced with additional information (or the SCR of someone you are a carer for), then please complete this form, to be returned to your GP surgery.

Name of patient: .....

Date of birth: ..... Patient's postcode: .....

Surgery name and location: .....

NHS number (if known): .....

Signature: ..... Date: .....

If you are filling out this form on behalf of another person, please ensure that you fill out their details and sign the form above, and provide your own details below:

Name: .....

Capacity: Please circle one	Parent	Legal Guardian	Lasting power of attorney for health and welfare

If you require any more information, please visit https://digital.nhs.uk/summary-care-records or speak to your GP Practice.