



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 may need to supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) 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:
*Any previous surname(s) (if applicable):	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
Town and country of birth:	
*Home telephone No.:	
Work telephone No.:	
*Mobile No. (if you have one):	

*First names:
*Date of Birth: DD / MM / YYYY
*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:
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:
Date left the Armed Forces:

Additional details about you

What is your ethnic group?	Main spoken language (E.g. English):
White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other White (please specify):	
Black <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black (please specify):	
Asian <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian (please specify):	
Mixed <input type="checkbox"/> White + Black Caribbean <input type="checkbox"/> White + African <input type="checkbox"/> White + Asian <input type="checkbox"/> Other mixed:	

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

(for women only) Have you had a cervical smear?
<input type="checkbox"/> Yes <input type="checkbox"/> 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 whose 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	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack	<input type="checkbox"/> Yes	Year
Angina (stable / unstable)	<input type="checkbox"/> Yes	Year
Stroke	<input type="checkbox"/> Yes	Year
Transient Ischaemic Attack	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year

Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year
Mental Illness (inc Depression)	<input type="checkbox"/> Yes	Year
Diabetes (type 1 or type 2)	<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

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:

If you are a student

MENINGITIS ACWY IMMUNISATION
 NHS England strongly recommends anyone who is starting university aged between 18-24yrs have an ACWY booster if you haven't already done so.

Yes, I would like a booster (if you tick this please talk to your university or call us to book an appointment)
 No, I would not like a booster
 I have already had a Men ACWY booster on (date):.....

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
Diabetes	<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
Other (please specify)		Who

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

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 **Would you like information or advice about alcohol consumption?**
 16-19 = harmful drinking 20+ = possible dependence Yes No

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

Communication Preferences

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 Letter Post

Data Sharing

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). The Core SCR includes important information about your health: Medicines you are taking, allergies you suffer from and 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 and 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 and Additional SCR**

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 broader 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 <https://healthcaregateway.co.uk/>

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

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:

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/>

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 online. This service is known as **Patient Access**. To register 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 registration letter within **seven working days**. You'll use this letter to create your online account. Please note **you must have an email address to use this service and given consent to receive emails from Billesdon Surgery**. Full terms and conditions are available on the application form.

Once you are registered...

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**

DD / MM / YYYY

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

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 <u>non-UK</u> EHIC or PRC?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please enter details from your EHIC or PRC below:
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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.

FOR OFFICE USE ONLY			
Date: _____	Staff Initials: _____		
PHOTO ID <input type="checkbox"/>	TYPE: _____	ADDRESS ID <input type="checkbox"/>	TYPE: _____
(Aged 18 and over only)			
ID exempt (returning university students only) <input type="checkbox"/>			