Please complete all sections of the form in CAPITAL LETTERS otherwise it may result in a delay of your registration

DE MONTFORT SURGERY STUDENT PATIENT REGISTRATION FORM

PATIENT DETAILS

NHS Number:	Previously Registered at De Montfort Surgery ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Title: Mr/Mrs/Miss/Ms/Dr/Other …..	☐ Student ☐ Non Student ☐ DMU Staff

Surname:	Previous Surname:
First Name:	Town + Country of Birth:
Middle Names:	Date of Birth:

CONTACT DETAILS

Leicester Address Room Number: Flat Number: Hall: Road: Post Code:	Mobile: Home Telephone: Email: What is your preferred contact method? ☐ Telephone ☐ Email ☐ Letter
Previous Home Address:	Next of Kin Details Name: Relationship: Telephone: By completing this section you are giving consent for us to contact the above named person in an emergency
Registered GP whilst at above address:	
	If you have recently moved to the UK please state date of entry:

Have you ever been employed within the Armed Forces? ☐ Yes ☐ No

Personnel Number: Date Enlisted: Date Left:

MEDICAL INFO

Do you suffer from any existing medical conditions?	Significant Past Medical/Mental Health History:
	Family Medical History (please state family member and condition.)
Are you on any current medication?	Any known allergies (please specify)

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.

TB Information

Are you aged between 16-35 years	☐ Yes ☐ No
Have you previously tested or treated for TB	☐ Yes ☐ No
Have you lived in England for less than 5 years	☐ Yes ☐ No
Have you lived in a high incidence country for 6 or more months	☐ Yes ☐ No

Meningitis Information

Have you had all the recommended childhood/adult immunisations including Meningitis ACWY? ☐ Yes ☐ No

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*Do you have a Disability? ☐ Yes ☐ No

If yes, please tell us how we can support your needs:

* Do you have a communication need that is related to your disability? ☐ Yes ☐ No

If you have answered yes, please tells us what communication need you have:

☐ Use hearing loop	☐ Use lip speaker	☐ Use hearing aid
☐ Use British Sign Language	☐ Use cued speech cued translator	☐ 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	If Other, please tell us how we can support your communication need:	

*Do you require information in a preferred format? ☐ Yes ☐ No - Select

If you have another specific communication need please specify:

☐ Requires contact by telephone	☐ Requires contact by email	☐ Requires contact by letter
☐ Requires contact by text relay	☐ Requires information in Makaton	☐ Requires information in braille
☐ Requires information in Makaton	☐ Requires information in braille	☐ Requires information in large font
☐ Requires information in EasyRead	☐ Medicine labelling large print	☐ Requires audible alert
☐ Requires visual alert	☐ Requires tactile alert	☐ Requires communication partner
☐ Deafblind communicator guide	☐ Face the client communicating	☐ Interpreter needed -BSL
☐ Deafblind telephone user	☐ Other, please tell us:	

ADMINISTRATION INFORMATION

*What is your ethnic group?

(Choose an option that best describes your ethnic group or background)

☐ British	☐ Irish	☐ Northern Irish
☐ Caribbean	☐ African	☐ Asian
☐ Indian	☐ Pakistani	☐ Chinese
☐ Other: Please specify		

*Main spoken languages

☐ English

☐ Other (please specify)

Interpreter required?

☐ Yes ☐ No

* Which of the following best describes you?

☐ Heterosexual (Straight)	☐ Male homosexual (Gay)	☐ Transgender gender reassignment patient
☐ Bisexual	☐ Female homosexual (Lesbian)	☐ Transgender gender identity disorder

Are you a carer? ☐ Yes ☐ No

Do you have a carer? ☐ Yes ☐ No

Please give any other relevant information:

Looked after Children *Please note you have a duty to notify social care of this arrangement*

Are you looking after someone else's child? ☐ Yes ☐ No

If Yes, under what arrangements:

☐ 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 arrangement		

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/or who is not your child

Who has the legal responsibility for the child?	Who can consent for the medical treatment for the child?
☐ You as the legal parent / guardian	☐ You as the legal parent / guardian
☐ Other (please specify)	☐ Other (please specify)

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LIFESTYLE INFO

Height:	**Exercise:** ☐ None ☐ Some ☐ 3 times a week
Weight:	**Smoking:** ☐ Current ☐ Ex-Smoker ☐ Never smoked

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	☐ 2-3 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
How often during 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 during the last year you failed to do what was normally expected from you because of your drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
Have you or somebody 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 you cut down?	☐ No		☐ Yes, but not in the last year		☐ Yes, during the last year

Females Only

Date of last Smear: (If known)

Contraception Used:

HEALTH CHECK: Are you between 40-74 years old? ☐ Yes ☐ No

If you answered yes to the above you are eligible for a free NHS Health Check with our health care assistant.

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PATIENT RECORD SHARING

We want to provide the highest quality of care and health services for all our patients.
By continuing to stay **opted in** to sharing your medical record, this will ensure that you to receive the best care and treatment from a number of places. These will include your GP practice, hospitals and community services.
Sharing your record will allow all medical staff to see your record and then make fully informed decisions about the care and treatment you require, whether you are here at De Montfort Surgery, or admitted to A&E in an emergency.
You will be asked your consent to share on each occasion.
N.B. Your medical record is linked via a secure system so your identity is protected.

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 ask at reception for a **'What is a Summary Care Record'** leaflet

For further information please visit:
https://digital.nhs.uk/summary-care-records/patients

Tick this box if you wish to **OPT IN** of 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.

For further information on MIG please visit:
http://www.healthcaregateway.co.uk/products

Tick this box if you wish to **OPT IN** of MIG ☐

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. De Montfort 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.

Tick this box if you wish to **OPT IN** of the Risk ☐

Electronic Data Sharing Module (EDSM)

De Montfort Surgery use a clinical computer system called SystmOne 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 SystmOne. These other services will always ask consent to view your record.

For more information please visit our website
www.demontfortsurgery.co.uk

Tick this box if you wish to **OPT IN** of the EDSM ☐

Please note that it is your responsibility to ensure your contact details are correct and you acknowledge this by signing this application form to register with De Montfort Surgery.

By giving us your mobile number you are agreeing to the surgery contacting you via text message.

Signature: _____

Date: _____

NHS Blood/Organ Donor Registration

I am already registered as an organ donor ☐

I would like to join the NHS organ donor register as someone whose organs may be used for transplantation after my death (Please tick)

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas
☐ Lungs ☐ Pancreas ☐ Any Body Part

Signature confirming consent to organ donation

_____

I would like to join the NHS blood donor register as someone who may be contacted to donate blood. ☐ Yes ☐ No

Have you donated blood in the last 3 years? ☐ Yes ☐ No