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:	Country and Town of Birth:
Middle Names:	Date of Birth:

CONTACT DETAILS

Leicester Address Room Number: Flat Number: Hall: Road: Post Code:	Mobile: Home Telephone: Email:

Please help us trace your previous medical records by providing the following information

Previous Home Address (Even if not in the UK):	Date you first came to live in UK:
	Have you been allocated an NHS number? ☐ Yes ☐ No If known, please specify: ☐☐☐☐☐☐☐☐☐☐
Name and address of Registered GP whilst at above address:	If previously a resident in the UK, date of leaving:

Next of Kin Details	Name:	**By completing this section you are giving consent for us to contact the above named person in an emergency**
	Relationship:	
	Telephone:	

Have you ever been employed within the Armed Forces? ☐ Yes ☐ No Personnel Number: Date Enlisted: Date Left:	**Office Use** Taken By:

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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? **If you have a Nominated pharmacy this will now need amending prior to making a new request for 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. If you are on the contraceptive pill please book a nurse appointment in advance.

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 ever lived in a high incidence country for 6 or more months ☐ Yes ☐ No
If Yes, please specify:

Vaccination Information

Have you had your Meningitis ACWY vaccination? ☐ Yes ☐ No ☐ Not sure

Have you had all of your MMR vaccinations? ☐ Yes ☐ No ☐ Not sure

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 a disability, impairment or sensory loss? ☐ Yes ☐ No

If you have answered yes, please specify:

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

If Yes, please specify:

ADMINISTRATION INFORMATION

What is your ethnic group?

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

White	☐ British	☐ Irish	☐ Other White (Please specify):
Black	☐ Caribbean	☐ African	☐ Other Black (Please specify):
Asian	☐ Indian	☐ Pakistani	☐ Other Asian (Please specify):
Mixed	☐ White and Black Caribbean	☐ White and Black Caribbean	☐ White and Black Caribbean

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 by profession? ☐ Yes ☐ No — If yes, do you look after someone who is a patient of De Montfort Surgery? ☐ Yes ☐ No — Their name:

Do you have a carer? ☐ Yes ☐ No — Their name and contact details:

Looked after Children	*Please note you have a duty to notify social care of this arrangement*
Are you a looked after child? ☐ Yes ☐ No	If Yes, Please give the Carers Full name and contact details:
Are you looking after a child that is NOT your own? ☐ Yes ☐ No	If Yes, Please give the Childs Full name and your relationship to them:

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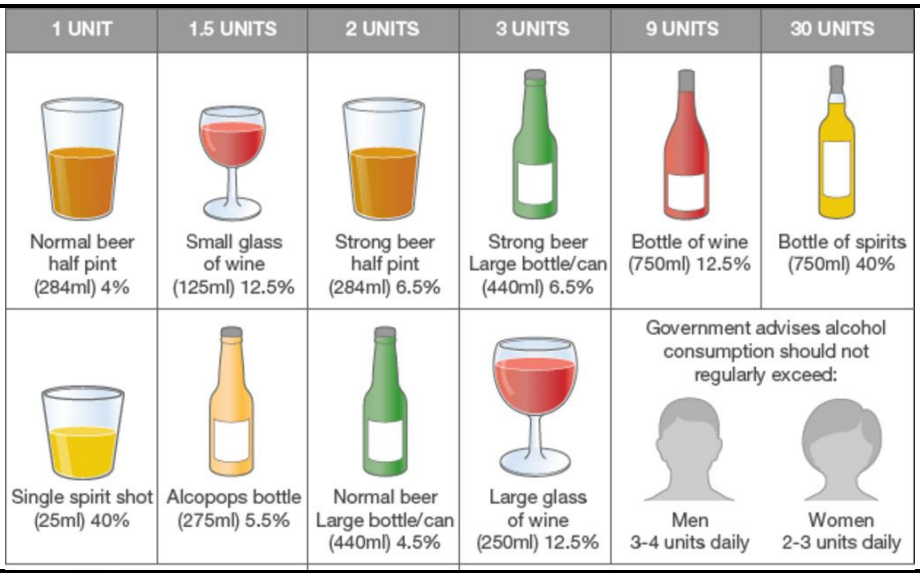
LIFESTYLE INFO

Height:	**Exercise:**	**Smoking Status:**
	☐ None	☐ Never smoked
	☐ Some	☐ Ex-Smoker Date stopped:
Weight:	☐ 3 times a week	☐ Social Smoker
	☐ 4+ times a week	☐ Smoker ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ VAPE
	☐ Competitive Athlete	☐ I would you like advice on quitting?

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

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.



Females Only

Date of last Smear and result: (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.

Communication Preferences

Do you consent to receive the following types of communication from De Montfort Surgery?

Email ☐ Yes ☐ No Mobile phone text messages ☐ Yes ☐ No

GP Online Services – Patient Online Access

Once your application to join our practice has been accepted you will 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**.

If you would like to arrange your Patient Access please ask for an Online Access Form. This will need to be completed fully and returned to the surgery with **one form of photo identification** (Passport / Driving Licence / Student Card)

We can only accept your request for Patient Access if your email address is valid and not shared by another person.

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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 fully protected.

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

Tick this box if you wish to OPT-OUT of the SCR ☐ **Tick this box if you wish to OPT -IN to the Core an Additional 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 further information on MIG please visit: www.healthcaregateway.co.uk/products

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 www.demontfortsurgery.co.uk

Tick this box if you wish to OPT-OUT of MIG and EDSM ☐ **Tick this box if you wish to OPT-IN of MIG and EDSM** ☐

Risk Stratification Preferences

Risk stratification data is shared between primary and secondary care NHS providers for the purposes of predicating potential future health needs of individuals and / or whole populations - For more information please visit our website

Tick this box if you wish to OPT-OUT of Risk Stratification ☐

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 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)

☐ Any of my organs and tissue or…
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas
☐ Lungs ☐ Pancreas ☐ Any Body Part

Signature confirming consent to organ donation

_____

NHS Blood Donor Registration

I am already registered as a blood donor ☐

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