Patient Registration Form

Woodbrook Medical Centre
28 Bridge Street, Loughborough, LE11 1NH
01509 239166
www.woodbrookmedicalcentre.co.uk

Thank you for applying to join Woodbrook Medical Centre. 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 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 day / month/ year
* ☐ Male ☐ Female	*NHS No. ☐☐☐☐☐☐☐☐☐☐
*Town and country of birth	*Home address
*Home telephone No.	*Postcode
Work telephone No.	
*Mobile No. (if you have one)	Email address **(this cannot be a shared or work email address)**

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

*Previous address in the UK (if applicable)	*Name of previous doctor
	*Address of previous doctor
*Postcode	Reason for leaving previous practice

If you are from abroad

*Your first UK address where you registered with a GP if you were previously living abroad	*If previously a resident in the UK, date of leaving
Postcode	*Date you first came to live in the UK (if applicable)

If you are returning from the Armed Forces

Address before enlisting	Service or Personnel No.	
Postcode	Enlistment date:	Leaving date:

Are you a Military Veteran?

☐ Yes ☐ NO

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

What language do you speak? Do you require an interpreter? ☐ YES ☐ NO

What is your marital status?

☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Cohabiting ☐ Common Law Partnership

What is your Residential status?

☐ Living alone ☐ Living with family ☐ Living with companion ☐ Living in care home

☐ Living in warden attended accommodation ☐ Living in sheltered housing

Information and Communication Needs

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

☐ Registered Blind ☐ Registered Deaf ☐ Registered Deafblind ☐ Hearing difficulty
☐ Registered Partially Sighted ☐ Impaired vision ☐ Any other disability_____

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

☐ British Sign Language ☐ Makaton ☐ Easy Read ☐ Braille
☐ Audio aids ☐ Large Print ☐ Email/SMS text
☐ Other_____

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 Woodbrook Medical Centre? ☐ 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)

Are you an Adult with social care involvement?	If yes, please state the reason why
☐ Yes ☐ No	

Do you have a nominated patient advocate/ advocacy service or Lasting Power of Attorney?

☐ Yes ☐ No

Please give details:

If Registering a Child please complete the following:

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 parental or legal responsibility for the child?	If you are the parent/guardian/foster carer /kinship carer **but cannot** consent please detail below who can
☐ You as the legal parent/guardian/adoptive parent ☐ **Other** (please specify) Name: Contact Number: Evidence of parental responsibility (birth certificate/social care information) :	Name: Relationship to child: Contact Number:

Looked after Children

If a child, are they looked after? ☐ Yes ☐ No

If Yes, under what arrangements:

☐ Section 20-Voluntary Care ☐ Subject to an Interim Care Order ☐ Subject to a Full Care Order

☐ Placed for adoption ☐ Unaccompanied Asylum Seeker

Does the child have a social worker?	Home schooled. ☐
☐ **Yes** ☐ **No**	Name of Social Worker:

Are there any other Agencies involved in their care? ☐ **Yes** ☐ **No.** Contact Details:

Domestic Abuse: If domestic abuse is affecting your health you can speak to someone here.

Please tick this box if you would like a GP to contact you. ☐

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

Height
Weight
Waist measurement

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

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

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

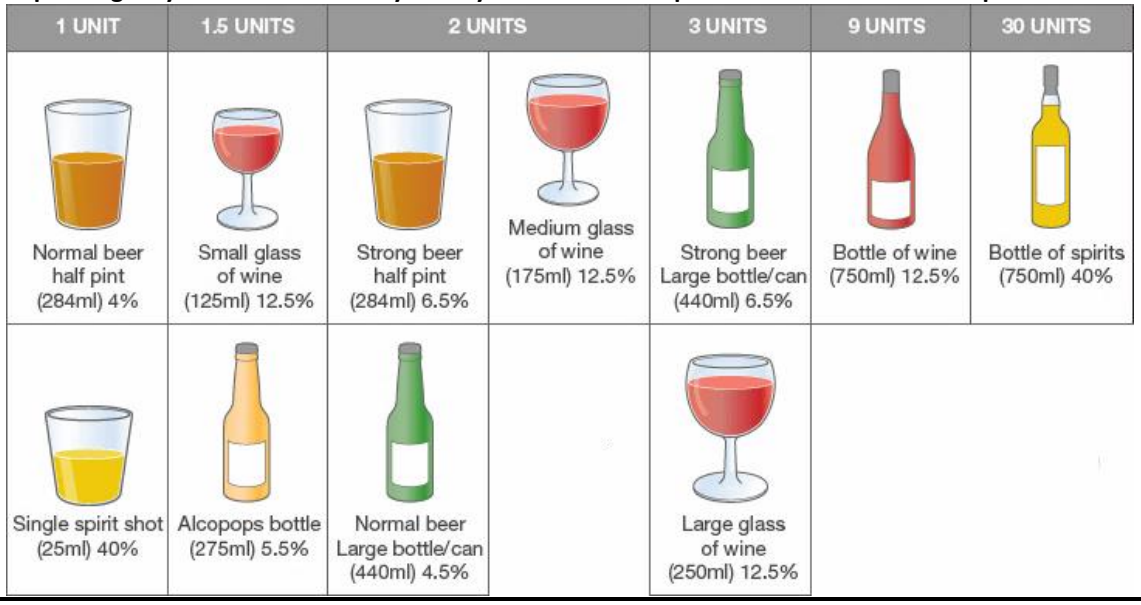
When did you quit?

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.



Additional Information

Please record any additional information about you that you think is important for us to know

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 using GP Online Services. This service is known as **SystmOnline**.

Once you are a fully registered patient of our practice you can visit *www.woodbrookmedicalcentre.co.uk* to begin your **SystmOnline** registration. This service is available to everyone with a valid email address. ***We can only accept your request for SystmOnline if your email address is valid and not shared by another person.***

Would you like to use SystmOnline? ☐ 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 post to you your **SystmOnline** details. Please let the practice know if you do not receive them within 14 days.

Summary Care Record (SCR)

A Summary Care Record is an electronic copy of the key information from your GP medical records. It provides authorised care professionals with faster, secure access to essential information about you when you need care. Healthcare staff will always ask your permission when they need to view your summary care record (except in an emergency when you are unconscious, for example) and only staff with the right levels of security clearance can access the system, so your information is secure.

A Core Summary Care Record contains information about:
Medicines you are taking
Allergies you suffer from
Bad reactions to medicines
An Enhanced (Additional information) Summary Care Record contains more information including:

Current and ended medications
Information about your long term health conditions
Your relevant medical information
Your healthcare needs and personal preferences such as where you would prefer to receive care, what support you might need, who should be contacted for more information about you
Immunisation history
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 and Additional SCR ☐

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

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

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.

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 From: **(a)**	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.

Practice Information

Patient Participation Group (PPG)

Woodbrook Medical Centre has a patient participation group that meets once a month. The meetings are held at the practice at 6pm on the 1st Thursday of the month.
The aim of this group is to give the patients the opportunity to have their say in the way the surgery works and the care that they receive.
Members of the PPG will receive agendas and minutes for the meetings they attend.

Would you like to join the panel of patients on our Patient Participation Group, receive emails and attend meetings?

☐ **YES** ☐ **NO**

If you have answered yes above please tick the appropriate fields below:

AGE:

☐ Under 16	☐ 17-24	☐ 25-34	
☐ 35-44	☐ 45-54	☐ 55-64	
☐ 65-74	☐ 75-84	☐ Over 84	

GENDER:

☐ Male ☐ Female

Patients will be contacted by email using the email provided on page one of this registration form, or via post if you do not have an email address.

If you would like more information about the PPG please see our PPG notice board at the practice, visit our PPG page on the practice website, visit the PPG website (www.woodbrookppg.org.uk) or ask at reception.

Woodbrook Medical Centre asks for this information in order to send you documentation about the meetings and activities of its Patient Participation Group.

Your details will be stored securely in Woodbrook Medical Centre's shared drive on the secured nhs.net portal and will be removed within one month if you end your membership of Woodbrook Medical Centre's Patient Participation Group.
You can withdraw your consent for us to use this information or ask us to amend or delete it at any time. To do this email woodbrook.mc@nhs.net or speak to us at reception.

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.

Electronic Prescription Service

The electronic prescription service allows us to send your prescriptions electronically straight to your chosen pharmacy. If you normally collect your repeat prescriptions from your GP practice you will not have to visit your practice in order to pick up your paper prescription, instead it will be electronically signed and sent to your pharmacy.
If you would like to nominate a pharmacy for us to send your prescription to electronically please list the name and location of the pharmacy here:

Woodbrook Medical Centre
Patient Communication Preferences –

We may need to send you text messages, emails or leave a message on your answering machine, if you have one.
May we contact you by:

☐ Text message ☐ Answering machine ☐ Email

Once you are registered…

If there are any problems with your registration we'll contact you to clarify any issues.

***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)