Burbage Surgery

Tilton Road, Burbage, Leicestershire, LE10 2SE
Tel: 01455 634879, Web: www.burbagesurgery.co.uk

Thank you for applying to join Burbage 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. **Include TWO photocopied 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:	*First names:
*Any previous surname(s) (if applicable):	*Date of Birth: DD / MM / YYYY
*☐ Male ☐ Female ☐ Intermediate ☐ Unspecified	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth:	*Home address:
*Home telephone No.:	*Postcode:
Work telephone No.:	Email address: (by entering an email address you consent to receive emails sent by our surgery)
*Mobile No. (if you have one):	

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

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 Burbage Surgery? ☐ Yes ☐ No ☐ Don't know

If yes, what is their name: Are they a ☐ Friend ☐ Relative ☐ Neighbour

Medical details

If you are taking repeat medication, please attach a copy of your repeat medication slip. If this is not included with your application, this may affect us being able to issue a further supply. We may request that you make an appointment with a GP 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	**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 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	☐ 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 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?	Are you an ex-smoker ☐ Yes ☐ No When did you quit? How many did you used to smoke a day?
Would you like advice on quitting? ☐ Yes ☐ No	

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:

Communication Preferences

We may want send you appointment reminders to your mobile and leave messages on your answering machine, if you have one.
Tick any of these boxes if you DO NOT wish to be contacted in this way:
☐ **Text message** ☐ **Answering machine**

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** ☐

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 repeat medications, book appointments and view certain aspects of your medical record online. This service is known as **Patient Access**. To register please download a form from our website or pick one up from reception. You'll be emailed a registration letter within **7 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 Burbage Surgery***. ***The email address cannot be the same as someone else with an account***. Full terms and conditions are available on the back of the application form.

Once you are registered…

New Patient Health-check

…You will be asked to attend for a new patient health-check with a Health Care Assistant. Please Contact reception to book an appointment when registered.

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:

***Signed**

***Date** DD / MM / YYYY

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

FOR OFFICE USE ONLY

Date:_____ Staff Initials:_____

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

ID exempt (returning university students only) ☐

Burbage Surgery
Patient Contact

Name of patient: ……

Date of Birth: ……

NHS Number: ……

I am a responsible patient. As such, I take full responsibilities for my health and my healthcare. My responsibilities include but are not limited to:

- Seeking medical advice when appropriate and in an appropriate way.
- Understanding the medical advice I receive.
- Asking questions when I do not understand the advice offered.
- Following medical advice when mutually agreed upon by my doctor /nurse and me.
- Taking my medications as prescribed.
- Notifying my doctor prior to stopping my prescribed medication.
- Notifying my doctor should I have any adverse reactions from my prescribed treatments.
- Ordering any repeat prescriptions in a timely fashion before they run out
- Keeping my appointments and attending for regular reviews when advised.
- Being an active partner in my medical care.
- Being honest about what I am doing, taking, and who I am seeing.
- **I will abide by the practices Zero Tolerance Policy and understand that I will be removed from the practice list of any unacceptable behaviour is reported.**

I understand that, without my active participation, my doctor's ability to help me is limited and any non-compliance to the above contract could be seen as a breakdown of relationship with the doctor/nurse and the practice, as such I could be asked to leave the practice and register elsewhere.

Signed by Patient ……

Date ……

Dr W Turner and Partners

Access to GP online services

Patient Online registration form

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

Application for online access

I understand and agree with each statement (please tick)

3. I will be responsible for the security of the information that I see or download	☐
4. If I choose to share my information with anyone else, this is at my own risk	☐
5. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
6. Children between the ages of 12 years to16 years will be required to complete the additional consent form. This form is available from Reception.	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			
Date passphrase sent			