**Johnson Medical Practice**

**Hilltop Surgery, 22 Maidenwell Avenue, Leicester, LE5 1BL**

**Tel: 0116 276 9555, Fax: 0116 276 9589**

**56 Melbourne Street, Leicester, LE2 0AS,Tel: 0116 253 6299, Fax: 0116 262 2928**

Thank you for applying to join Johnson Medical Practice. 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. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Fields marked with an asterix (\*) are mandatory.

|  |  |  |  |
| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First names |
| \*Any previous surname(s) | |  | \*Date of Birth |
| \*Male Female Intermediate Unspecified | |  | \*NHS No. |
| Town and country of birth | |  | \*Home address & Postcode  \*Previous address & Postcode |
| Home telephone No. Preferred Number Yes No | |  |
| Work telephone No. Preferred Number Yes No | |  |
| Mobile No. Preferred Number Yes No | |  | Email address |
|  | | | |
| \*Previous GP Details | |  | If you are from abroad please tell us your first UK address where registered with a GP:  If previously resident in UK, date of leaving:  Date you first came to live in UK: |
| (**for women only**) Have you had a cervical smear?  Yes No (*Please state where, when and the result if possible*) | |  | Marital Status?  Single Married Divorced Widowed |
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| **Have you ever been in the employ of the Armed Forces?**  Yes  No  ***Personnel Number:*** ***Date Enlisted: Date Left:***  **Are you a dependant of a current serving member of British Armed Forces?**  Yes  No |

**Additional details about you**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| What is your ethnic group?  **Religion……………………………**  Main Language Spoken?  (E.g. English)  **Interpreter required?**  **Yes No** | | | | | | |
| **White**  **Black**  **Asian**  **Mixed**  **Other** |  | British  Caribbean  Indian  White + Black Caribbean  *Please specify*: |  | Irish  African  Pakistani  White + African |  | Chinese  White + Asian |

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| **\* Which of the following best describes you?**  Bisexual  Female homosexual | Transgender gender reassignment patient |
| Male homosexual  Heterosexual | Transgender gender identity disorder |

**Next of kin \ Emergency contact**

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| --- | --- | --- |
| Name of next of kin \ Emergency contact |  | Relationship to you |

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| --- | --- | --- |
| Next of kin \ Emergency contact telephone number(s) |  | Next of kin \ Emergency contact address (if different to above) |

**Please provide information below if known**

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| Height ft in |  | (**for women aged 25 to 64**) Have you had a cervical smear test?  Yes No  If Yes Please state where, when and the result(if known) |
| Weight st lb |
| Waist measurement in |

**Data Sharing**

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| **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 refer to **‘What is a Summary Care Record’** document for more information **or visit:** [**https://digital.nhs.uk/summary-care-records/patients**](https://digital.nhs.uk/summary-care-records/patients)  **Tick this box if you wish to have an enhanced SCR with core and additional information (recommended)**  Tick this box if you wish to opt-out of the SCR |

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| **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.  **More information can be found by visiting: http://www.healthcaregateway.co.uk/products**  **Tick this box if you wish to opt-out of the MIG data sharing** |

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| **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. Johnson Medical Practice 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.  **For more information please visit our website at** [**www.johnsonmedicalpractice.co.uk**](http://www.johnsonmedicalpractice.co.uk)  **Tick this box if you wish to opt-out of the Risk Stratification programme** |

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| **Enhanced Data Sharing Module (EDSM)**  Johnson Medical Practice 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 at** [**www.johnsonmedicalpractice.co.uk**](http://www.johnsonmedicalpractice.co.uk)  **Tick this box if you wish to opt-out of the Enhanced Data Sharing Module** |

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| \*Do you consent to receive the following types of communication (if offered) from Johnson Medical Practice?  **Email** Yes No **Mobile phone text messages** Yes No **Answering machine messages** Yes No |

**Carers Information**

*A carer is a friend or 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.*

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| Are you looked after by someone who’s 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 |

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| 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 Johnson Medical Practice? Yes No  Don’t know  If yes, what is their name?  Are they a: Relative Friend Neighbour |

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| **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  (please note you have a duty to notify social care of this arrangement) | **Do you smoke?**   Yes  No  **If Yes, what do you primarily smoke:**  Pipe  Cigarettes  Cigar  Other  **How many do you smoke a day?**  **Would you like advice on quitting**?  Yes  No |

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| **Housing Status**  Lives alone  Lives with Family  Lives in a House  Lives in Sheltered housing  Lives in warden attended accommodation  Live in a residential home  Lives in nursing home | **Housebound Status**  Housebound  Temporarily housebound  No longer housebound | **Functional Details**  Feeding and Nutrition………………………………..  Continence Status………………………………………  Mobility……………………………………………………...  Shopping activities………………………………….....  Personal care……………………………………………..  Handing Money…………………………………………. |

**Medical details**

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| **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.** |

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| \*Are you allergic to any medicines?  Yes  No (if yes please specify) |

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| \*List other allergies / intolerances (i.e. nuts, gluten, 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?**

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| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | Yes | Year |  | **Mental Illness** | Yes | Year |
| **High Blood Pressure** | Yes | Year |  | **Diabetes** | Yes | Year |
| **Heart Attack / Angina** | Yes | Year |  | **Asthma** | Yes | Year |
| **Stroke / Mini-stroke (TIA)** | Yes | Year |  | **COPD (or Emphysema)** | Yes | Year |
| **Cancer** | Yes | Year |  | **Osteoporosis / Bone fractures** | Yes | Year |
| **Rheumatoid Arthritis** | Yes | Year |  | **Peripheral vascular disease** | Yes | Year |

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| 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. |

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| **The Accessible Information Standard (AIS)**  Please 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/**](https://www.england.nhs.uk/ourwork/accessibleinfo/)  \***Do you have a Disability?** Yes No  **If yes, please tell us how we can support your need:**  **\* 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 transiliteraor | 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: |   **If you have another specific communication need please specify:** Yes No (Choose below)   |  |  |  | | --- | --- | --- | | Requires contact by letter | 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: | |

**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 |

**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  (go to Page 4) | Monthly or less | 2 - 4 times  Per month | 2 - 4 times per month | 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 |
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| Do you exercise regularly?  Yes  No  If so – What exercise do you take?  How often? |
| \*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your behalf. Please complete this section if you would like to register a 3rd party.  I give consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to collect prescriptions on my behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)  I give consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to obtain test results / medical information / appointment information on my behalf (Delete as appropriate)  IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Electronic Prescription Service (EPS)**  EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as 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. |

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

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| **Patient Participation / Reference Group (PPG) (PRG) or Virtual Group.**  **PRACTICE TO AMEND THIS BOX WITH THE WORDING TO MEET THEIR PROCESSES FOR INVITING PATIENTS.** |

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| **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  Any part of my body  **For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23** |

|  |  |  |
| --- | --- | --- |
| **\*Signed** |  | **\*Date / / /** |

|  |  |
| --- | --- |
| **Signed on behalf of patient** (*if applicable*)  (e.g. for minors under 16 years old, adults lacking capacity) |  |
|  |  |

**Once you are registered…**

If there are any problems with your registration we’ll contact you to clarify any issues, but once your details have been entered into our computerized records…

On-line Services

…You will be able to register with our on-line service and access appointments, prescriptions and some sections of your own medical record via the internet.  All of the details that you need for this are available by requesting to be registered at reception or at [www.johnsonmedicalpractice.co.uk](http://www.johnsonmedicalpractice.co.uk) . Please complete attached form for online service.

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.

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| --- |
| **FOR OFFICE USE ONLY** |
| **PHOTO ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Over 18 only)  **ADDRESS ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Thank you for providing this information. We look forward to providing you with high standard of care in a friendly and professional manner.**

**Johnson Medical Practice**

**Hilltop Surgery Melbourne Surgery**

**22 Maidenwell Avenue 56 Melbourne Street**

**Leicester Leicester**

**LE5 1BL LE2 0AS**

**Tel: 0116 2769555 Tel: 0116 2536299**

**Fax: 0116 2769589 Fax: 0116 2629298**

**SystmOnline Request form**

**Patient information: Please read and sign below**

**Privacy Policy**

Johnson Medical practice is committed to protecting your privacy online. The personal information you enter on this website is strictly controlled. Information entered is available only to members of staff with appropriate access rights

**SystmOnline Usage**

Please use this service responsibly. In the case of any abuse of the service, Johnson Medical Practice can revoke your log-in details, stopping you accessing the service. Examples of irresponsible use of the system may include:

* Booking appointments you have no intension of attending
* Repeatedly booking and cancelling appointment
* Repeatedly requesting prescriptions that you do not need

**Patient Name………………………………………………………….. Patient signature………………………………………………….**

**­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**

Today’s date ……………………………………………………………………………………………………

Patient Name ……………………………………………………………………………………………………

Patient Address ……………………………………………………………………………………………………

NHS Number ……………………………………………………………………………………………………

**Patient must provide 1 form of Photo ID & Proof of Address**

Passport No…………………………………………………….  **OR** Drivers Licence No……………………………………..

Utility Bill / Bank Statement (under 3 months old **[ ]**

**Patient under 16 years of age must provide 1 of following**

Passport No ………………………………………………… **OR** Birth Certificate …………………………………….……

**Admin Use (Please Tick)**

Is the patient **‘SystmOnline Registration Details’** Printed Clearly? **[ ]**

Attach **‘Patient Information Sheet’** with Registration Details

and hand it over to the patient for them to take away with them **[ ]**

Staff Name ……………………………………………..……..