**DOWNING DRIVE SURGERY**

**155 DOWNING DRIVE, EVINGTON, LEICESTER, LE5 6LP**

**0116 2413801**

[**www.downingdrivesurgery.nhs.uk**](http://www.downingdrivesurgery.nhs.uk)

Dear Patient(s),

We would like to welcome you to our Practice and explain a few of our registration procedures to you.

Please fill in the accompanying form(s) and return to the surgery with ‘ideally’ a proof of your new address:

1. Proof of where you are living currently, in the form of a utility bill, a bank statement, allowance book or driving licence, with your name and address on it

2. Medical card if possible

3. Any vaccine details (red book for children)

4. Consent form to leave messages or speak to another person

5. Sharing Consent forms signed

6. ID is required to register for on-line services in the form of a Driving Licence, Passport, Buss Pass, Bank Statement or Utility Bill.

Please allow approximately 10 working days for your registration to be completed.

When registered and if you need to see a Doctor please book a double appointment for your first visit.

If you have requested on-line services, you will receive the username and password via text message or be asked to collect it from the surgery

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

For patients who live just outside of our contracted practice area but have been accepted to join the practice by the Doctors, please be aware that any visitors to your address cannot be seen as temporary residents. Registrations will need to be contacted as above and please ask for the specific GP that covers your address.

For further information about Downing Drive Surgery, please visit our website www.downingdrivesurgery.nhs.uk.

Yours sincerely

Katie Billson Practice Manager

**GP Service – Patient Registration Form (Children)**

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| **FOR OFFICE USE ONLY**  **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Initials: \_\_\_\_\_\_\_\_\_\_** |
| **PHOTO ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ADDRESS ID  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Aged 16 and over only) |

Downing Drive Surgery  
155 Downing Drive, Leicester, LE5 6LP  
0116 2413801  
downingdrivesurgery.nhs.uk

Thank you for applying to join Downing Drive 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 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 the form in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form. Fields marked with an asterix (\*) are **mandatory**

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| --- | --- | --- | --- |
| \*Title: | \*Surname: |  | \*First names |
| \*Any previous surname(s) (if applicable): | |  | \*Date of Birth **DD / MM / YYYY** |
| \*Male Female Non-binary Prefer not to say  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \*NHS No. |
| Town and country of birth: | |  | \*Home address |
| \*Home telephone No.: | |  |  |
| \*Mobile No. (if you have one): | |  | \*Postcode: |
| Which is your preferred number?  \*Home telephone no. Mobile No. | |  | 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: | |  |  |

**If you are from abroad**

|  |  |  |
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| \*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: |
|  |  | \*Date you first came to live in the UK (if applicable): |
| \*Postcode: |  |  |

**Additional details about you**

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| \*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  **Other**  Prefer not to say  (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*Information and Communication Needs – PLEASE ANSWER ALL QUESTIONS.**

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| Does the child speak English?  **Yes**  **No**  **Yes, but not very well.**  Does the child use non-verbal language as your main form of communication?  **No**  **I use British sign language,**  **I use Makaton sign language,**  **I use a speech to text reporter,**  What is the child’s main spoken language?   **English**  **Gujarati**  **Punjabi**  **Arabic**  **Polish**  **French**  **Hindi**  **Bengali**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Does the child need a language interpreter?  **Yes**  **No**  Does the child have any communication difficulties?  **No**  **Hearing difficulties,**  **Visual difficulties,**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Does the child require any accommodations for accessibility?  **Yes**  **No**  If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

**Looked after Children**

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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) |

**Is the child you are registering on a child protection plan? Yes or No**

**Carer/Next of Kin Relationship Information**

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| \*Do you have a Carer? Yes No If yes, their contact details:  Do you consent for your carer to be informed about your medical care? Yes No |

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| Are you a Carer? Yes No  If yes, do you look after someone who is a patient of Downing Drive Surgery Yes No  Don’t know  If yes, what is their name? Are they a: Relative Friend Neighbour |

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| Name of next of kin: |  | Relationship to you: |

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| Next of kin telephone number(s): |  | Next of kin address (if different to above): |

**Medical Details and Lifestyle Habits**

**In order to receive your repeat medications, you’ll need to make an appointment at the surgery at least one week before your next prescription is due.**

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| **Please list you repeat medications here:** |
| \*Is the child allergic to any medicines?  Yes  No (if yes please specify) |

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| \*List other allergies (pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of: |
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**Has the child ever had any of the following conditions?**

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| --- | --- | --- | --- | --- | --- | --- |
| **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 |

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| List any serious illnesses /operations /accidents /disabilities & the year they took place: |

**Do the child have family history of any of the following?**

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| --- | --- | --- | --- | --- | --- | --- |
| **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 |

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| --- | --- | --- |
| Height ft. in |  |  |
| Weight St. lb |
| Waist measurement in |

**Communication Preferences**

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| \*Do you consent to receive the following types of communication from Downing Drive Surgery?  **Email** Yes No  **Mobile phone text messages** Yes No  **Answering machine messages** Yes No  **Letter** Yes No |

**GP Online Services – Patient Online Access**

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| 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**.  \*Please note children under the age of 13 will typically be added onto a parent/guardian’s SystmOnline, giving them access. Once a child turns 13 years old they will be removed from their parent/guardian’s SystmOnline and will be asked to book in for a **Gillick Competency** test with the GP. This is to check whether the child is competent enough to have access to their own SystmOnline or whether a parent/guardian should continue to have access\*  **Would you like the child to use SystmOnline?** Yes  No  If yes, please specify the e-mail address you wish to use for GP Online access and the name of the parent/guardian it should be attached to  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  You will either get a text message with your log in details or asked to collect it from the surgery. |

**Data Sharing**

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| **Electronic Data Sharing Module (EDSM)**  Healthcare places can usually share information from your records by letter, email, 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 at** www.downingdrivesurgery.nhs.uk  **Tick this box if you wish to opt-in to the EDSM**  **Tick this box if you wish to opt-out to the EDSM** |

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| **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-in to the Core SCR**  **Tick this box if you wish to opt-in to the Core an Additional SCR**  **Tick this box if you wish to opt-out of the SCR** |

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| **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 more information please visit the Sharing Your Medical Record page on our website at** www.downingdrivesurgery.nhs.uk  **Tick this box if you wish to opt-out of the MIG**  **Tick this box if you wish to opt-in of the MIG** |

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| **SUPPLEMENTARY QUESTIONS** | | | |
| **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:** |  |

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| **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 (a) From:** | **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. | | | |

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

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| **\*Signed** |  | **\*Date DD / MM / YYYY** |

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