FOREST HOUSE MEDICAL CENTRE & WARREN LANE SURGERY
2a Park Drive
L.F.E.
Leicester LE3 3FN
Tel: 0116 2898111, web: www.foresthousemedicalcentre.co.uk

Thank you for applying to join Forest House Medical Centre & Warren Lane Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving licence) and proof of your home address (such as a recent bank statement or document relating to your new home)**
Please note if you do not complete the form fully you may not be able to register

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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	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address *Postcode
*Home telephone No.	
Work telephone No.	
*Mobile No. (if you have one) Please advise who this belongs too? Do you consent to receive text messages on this number for the patient Yes ☐ No ☐	Email address

Previous address

*Previous address in the UK Postcode

Previous GP details

Name of previous doctor while at that address
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

*Main spoken languages ☐ **English** ☐ **Other** (please specify) Interpreter required? ☐ Yes ☐ No

*What is your ethnic group? (Please circle the option that best describe your ethnic group or background)

White		English/Welsh/Scottish		Northern Irish		Irish
Black		Caribbean		African		Other
Asian		Indian		Pakistani		Chinese
Mixed		White + Black Caribbean		White + African		White + Asian
Other *Please specify*:						

Additional details about your child:

Who has the parental or legal responsibility for the child?

☐ You as the legal parent/guardian/adoptive parent

☐ **Other** (please specify)_____

Name: _____

Contact Number:

Evidence of parental responsibility (birth certificate/social care information): _____

If you are the parent/guardian/foster carer /kinship carer **but cannot** consent, please detail below who can

Name: _____

Relationship to child: _____

Contact Number: _____

Looked after Children

Is the Child 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

☐ Private arrangement/Private Fostering/informal arrangement

(Please note you have a duty to notify social care of this arrangement)

What is Private Fostering?

A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

*Private Fostering **includes** a child living with:*	*Private Fostering **does not include** a child living with:*
• godparents • great-grandparents • great aunts or uncles • family friends • stepparents where a couple isn't married or in a civil partnership • cousins • a host family which is caring for a child from overseas while they are in education here	• brothers • sisters • grandparents • aunts • uncles • stepparents where a couple is married or in a civil partnership • mother • father • children and young people who are being looked-after by the Local Authority

Name of school or nursery:	Home schooled. ☐
Does the child have a social worker? ☐ **Yes** ☐ **No**	Name of Social Worker:
Are there any other Agencies involved in their care? ☐ **Yes** ☐ **No. Contact Details:**	

Data Sharing

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk**

Do you consent to the Summary Care Record (SCR)?

Yes ☐ No ☐

Do you consent to the Enhanced Summary Care Record (this will include as above plus a more detailed summary of your medical history including e.g. immunisations, major diagnoses & long term conditions? Yes ☐ **No** ☐

Medical Interoperability Gateway (MIG)

Whilst the SCR mentioned 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.

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

Medical details

Please attach any repeat medication you have on a regular basis.

*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)

Do you wish to nominate a pharmacy for prescriptions to be electronically sent?
If yes, please enter the pharmacy you wish to nominate ……
(Please ask at reception for further information)

Immunisations
If you are from abroad, please give a copy of your immunisations.

If a child - are they up to date with their immunisations? ☐ Yes ☐ No (if not please specify)

Have you ever had any of the following conditions?

Polio	☐ Yes	Dates	**Whooping Cough**	☐ Yes	Dates
Diphtheria	☐ Yes	Dates	**Hib**	☐ Yes	Dates
Tetanus	☐ Yes	Dates	**Hep A or B**	☐ Yes	Dates
MMR	☐ Yes	Dates	**Meningitis**	☐ Yes	Dates
Pneumococcal	☐ Yes	Dates	**Typhoid**	☐ Yes	Dates
Yellow Fever	☐ Yes	Dates	**Other please name**	☐ Yes	Dates

List any serious illnesses asthma /diabetes/ operations / accidents / disabilities etc

***Signed**

***Date** (dd/mm/yyyy) / /

Signed on behalf of patient (*if applicable*)
(Minors under 16 years old, adults lacking capacity)

Full Name:

Relationship:

Do you have any additional communication requirements? i.e. Braille, Large Print ……