**FOREST HOUSE MEDICAL CENTRE & WARREN LANE SURGERY**

**2a Park Drive**

**L.F.E.**

**Leicester LE3 3FN**

**Tel: 0116 2898111, web:** [**www.foresthousemedicalcentre.co.uk**](http://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**

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 |
| \*Home telephone No. |  |  |
| Work telephone No. |  | \*Postcode |
| \*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 GP details** |
| \*Previous address in the UK |  | Name of previous doctor while at that address |
|  |  | Address of previous doctor |
| Postcode |  |  |

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

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| \*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***:** |  |

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| --- |
| \*Main spoken languages |
| [ ]  **English** |
| [ ]  **Other** (please specify) |
| Interpreter required? |
| [ ]  Yes | [ ]  No |

**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 canName:Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: |
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**Looked after Children**

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| Is the Child looked after? [ ]  Yes [ ]  NoIf 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
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|  |  |
| --- | --- |
| 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**

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

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| --- |
| \*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)

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| **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 |

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

|  |  |  |
| --- | --- | --- |
| **\*Signed** |  | **\*Date** (dd/mm/yyyy) **/ /** |

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| **Signed on behalf of patient** (*if applicable*) **Full Name:**(Minors under 16 years old, adults lacking capacity)  |
|  **Relationship:** |

**Do you have any additional communication requirements**? i.e. Braille, Large Print ……………………………………………
(staff to code XaIKS if any needs identified)