FOSSE MEDICAL CENTRE

Dr Hafiz Mukadam
Dr Nina Sharma, Dr Valentina Topala, Dr Ajish John, Dr Edmund Mathew
Salaried GPs – Dr Domine McConnell
Mrs Vicky Hill – Practice Manager

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344 Fosse Road North, Leicester, LE3 5RR
Tel: 0116 2957100

Before filling in the forms:

- Visit https://www.fossemedicalcentre.co.uk/about/catchment-area to check you live in our catchment area. Any registration forms received for patients not living in our catchment area will be destroyed.
- Use the machine in the waiting area to check your height, weight and BP so that you can fill in the form COMPLETELY. Any incomplete forms that we receive will be destroyed. If any parts of the form do not apply to you, cross them out, do not just leave them blank.
- Bring proof of address (dated within past 6 months) and photo ID, if you have it.
- **If you are registering a child under 18** who has been vaccinated outside of the UK please provide proof of their immunisation history. Further information on this can be found at https://www.gov.uk/government/publications/uk-and-international-immunisation-schedules-comparison-tool
- If you take regular medication, you may need to attend the surgery for a New Patient Health Check. Please ensure that all your contact details are correct so that we can get in touch with you to book this.
- If we cannot contact you within 2 weeks of receiving them, then the registration forms will be destroyed.

READ AND CHECK THE ABOVE INFORMATION BEFORE FILLING IN THESE FORMS.

FOLLOWING RECEIPT OF THIS COMPLETED FORM, your details will be entered into our computerized records and you will then have access to the following via **www.fossemedicalcentre.co.uk**:

Online Services: You will be able to register to access appointments, prescriptions and your medical records.

Electronic Prescribing: Your prescriptions will be sent electronically to your nominated chemist, you need to speak to your regular chemist to organise this.

Use the NHS App to:

- order your repeat prescriptions
- book and manage appointments at your GP surgery
- message your GP surgery, doctor or health professional online
- view your health record securely
- access health services on behalf of someone you care for
- get health information and advice
- register your organ donation decision
- find out how the NHS uses your data
- get your NHS COVID Pass
- get advice about coronavirus

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Download on the App Store SCAN ME

New Patient Registration Form - Fosse Medical Centre

344 Fosse Road North, Leicester. LE3 5RR
Tel: 0116 2957100/01, Web: www.fossemedicalcentre.co.uk

Thank you for choosing Fosse Medical Centre but you MUST complete this form ASAP to complete your registration.

You also must 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 all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.
Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s) (if applicable)	*Date of Birth
*☐Male ☐Female	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address *Postcode
Home telephone No. ☐☐☐☐☐☐☐☐☐☐☐	
*Mobile No. ☐☐☐☐☐☐☐☐☐☐☐	
Work telephone No. ☐☐☐☐☐☐☐☐☐☐☐	*Occupation
Email address	*Religion

Your previous address

*Previous UK address if applicable) Postcode

Previous doctor's details

Name of previous GP
Address of previous GP

If you are from abroad

*Your first UK address where you registered with a GP Postcode	*If previously a resident in the UK, date of leaving
	*Date you first came to live in the UK (if applicable)

Tick this box if you have you ever served in the Armed Forces ☐

If you are returning from the Armed Forces

Address before enlisting Postcode	Service or Personnel No.
	Enlistment date

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

Do you need an interpreter?

☐ Yes ☐ No

Required language:

_____

☐ British Sign Language (BSL)

FUTURE COMMUNICATION:

*Do you consent to receiving the following types of communication from Fosse Medical Centre?

Email ☐Yes ☐No

Mobile phone text messages ☐Yes ☐No

Answering machine messages ☐Yes ☐No

Circle one method below as your preferred text based method of contact:

SMS Email Letter

Carer Details:

Do you have a Carer? ☐Yes ☐No Their name & contact details:

What type of carer are they: Young carer, under 18 ☐ Paid as a job ☐ Unpaid, but may get benefits ☐ Foster carer ☐

Do you consent for your carer to be informed about your medical care? ☐Yes ☐No

Are you a Carer? ☐Yes ☐No

What type of carer are you: Young carer, under 18 ☐ Paid as a job ☐ Unpaid, but may get benefits ☐ Foster carer ☐

If yes, do you look after someone who is a patient of Fosse Medical Centre? ☐Yes ☐No ☐ Don't know

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

Next of Kin:

Name of next of kin	Relationship to you

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

Allergies:

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify the allergy and reaction you suffer e.g rash)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Common Chronic Conditions - 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

Other Past or Long Term Medical Problems:

Please list any other serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place:

1)

2)

3)

Active Medical Problems – Are you under any hospital specialists, awaiting outpatient appointments or requiring your new GP to arrange these?

Please provide as much detail as possible:

Name of Consultant	Speciality	Name of Hospital	Reasons for seeing

Medications:

Please provide as much details as possible:

Name of Medication	Dose (e.g. milligrams)	How many times per day?	Reasons for taking it

if you have more than 4 regular medications please list them in the additional information section at the end of the page, or blank page at the end of the form.

PLEASE RECORD THESE USING MACHINE IN THE WAITING AREA –

our reception team can help

Blood pressure			
Height	m /	ft	in
Weight	kg /	st	lb
Waist circumference	cm /		in

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION

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

My regular and nominated chemist is: or tick for the closest pharmacy ☐

Please record any additional information that you think might be important for us to know:

FAMILY HISTORY – Does any relative suffer from?

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

Diet

How would you rate your current diet/nutritional intake?
Poor / Average / Good (please circle the most appropriate)

Do you Smoke? Yes or No (please circle)

If YES

What do you primarily smoke:
Cigarettes / Cigar / Pipe **(please circle)**

And how many per day:

If you would like help to stop smoking – please e-mail livewell@leicester.go.uk or call 0116 454 4000.

If NO

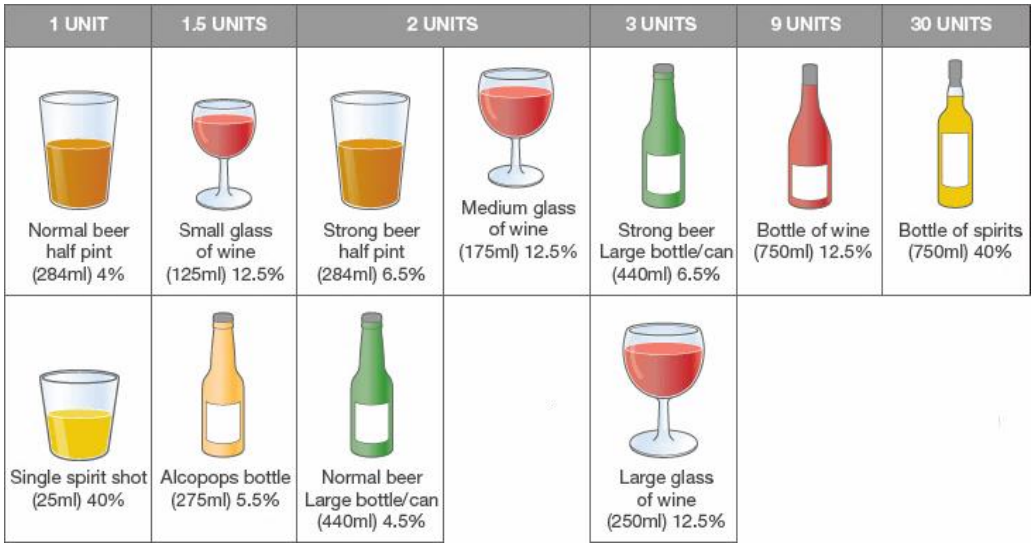
Have you ever smoked? ☐ Yes ☐ No
If an ex-smoker, when did you quit?

How many did you used to smoke a day and how long did you smoke for?

Do you consume Alcohol? Yes or No (please circle)

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

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.



***Signed**

***Date** / / /

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

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE:** _____ **ADDRESS ID** ☐ **TYPE:** _____
(Aged 16 and over only)

ID exempt (returning patient) ☐

COVID – 19 Vaccinations

Please fill in the information below if you have had any Covid-19 vaccinations

Vaccinaction Part	Vaccine Brand	When it was given	Batch Number	Where it was given (Country)
1st	☐ Johnson & Johnson ☐ AstraZeneca ☐ Pfizer ☐ Moderna ☐ Other:_____			
2nd	☐ Johnson & Johnson ☐ AstraZeneca ☐ Pfizer ☐ Moderna ☐ Other:_____			
Booster	☐ Johnson & Johnson ☐ AstraZeneca ☐ Pfizer ☐ Moderna ☐ Other:_____			

If you have had more than 3 vaccination parts, as in the above table, please list them in the table below:

Vaccinaction Part	Vaccine Brand	When it was given	Batch Number	Where it was given (Country)

IMMUNISATION HISTORY (Under 18's only)

If your child was born outside of the UK, please bring in a record of their immunisation history.

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FORM CONTINUES ON THE NEXT PAGE

SHARING YOUR MEDICAL RECORDS

Your medical information may now be used by your GP and other healthcare providers in new ways. You have a choice about this. If you want to discuss any of this information please ask to speak to the practice manager. Please tick the box next to the relevant section then fill in your details at bottom of this sheet and hand it in to reception.

Summary Care Record (SCR) *[clinical tree]*

- **What it is:** Basic but important details relating to the medicines you take, allergies you have and any medicines that make you ill.
- **Who it's shared with**: healthcare professionals in Hospital A&E Departments and GP 'Out of Hours' health services.
- **Why it's useful**: could be particularly important in an emergency situation when you may not be able to talk directly to those caring for you. SCR helps clinicians to give you safe, timely and effective treatment.

☐ **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had.

☐ **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had **AND** any other information that I have agreed with my GP Practice to have included in my Summary Care Records.

☐ **NO** I do not want a Summary Care Record.

Enhanced Data Sharing Model (eDSM) *[clinical tree - hand]*

- **What it is**: your GP records.
- **Who it's shared with**: Health care professionals at another NHS establishment (such as a Walk In Centre, Urgent Care Centre, Community Services etc.)
- **Why it's useful**: If you attend for medical reasons to get the best possible treatment. However, they will only be able to view your records if they ask your permission to do so and they must record that you agree to this. If you do not agree they will not view your record.

Sharing OUT controls whether information recorded at our GP Practice can be shared with other NHS health care providers.

☐ **YES** share data with other NHS organisations.

☐ **NO** do not share any data recorded by my GP Practice; I fully accept the risks associated with this decision.

Sharing IN determines whether or not our GP Practice can view information in your record that has been entered by other NHS services (that you have consented to share out).

☐ **YES**, consent given.

☐ **NO**, consent refused; I fully accept the risks associated with this decision.

National data opt-out (Type 2 objection)

- **What it is:** information about your care. The type 2 objection tells NHS Digital not to share your ***confidential patient information*** for purposes beyond your individual care (i.e. for research and planning).
- **Who it's shared with:** NHS commissioning bodies, local authorities, university and hospital researchers, medical colleges and pharmaceutical companies researching new treatments.
- **Why it's useful:** Your health and care information is used to improve your individual care. It is also used to help research new treatments, decide where to put GP clinics and plan for the number of doctors and nurses in your local hospital. Wherever possible Health and Social Care Information Centre (HSCIC) try to use data that does not identify you, but sometimes it is necessary to use your confidential patient information.

You do not need to do anything if you are happy about how your confidential patient information is used.

If you do not want your confidential patient information to be used for research and planning, you can choose to opt out securely online or through a telephone service.

You can change your choice at any time. To find out more or to make your choice:

- Download NHS App
- visit www.nhs.uk/your-nhs-data-matters
- call **0300 303 5678**
- you must have an email address or phone number registered with an NHS service. Ask your GP surgery for help if you need to confirm your contact information is up-to-date

Full Name: …… Date of Birth: ……

Signature: …….. Today's date: ……