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The Leith Hill Practice

The Old Forge Surgery
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www.leithhillpractice.co.uk

Welcome to the Leith Hill Practice

Thank you for your interest in registering with us. As a GP training practice we offer quality medical care of the highest standard and aim to treat all our patients as individuals – please see our Practice Leaflet or website for a list of our services.

All new patients aged 16 and over will need to complete a Registration Form **and** Screening Questionnaire. When completed, return to the surgery along with copy each of proof of identity and address.

New patients under 16 **only** need only complete a Registration Form. When completed, return to the surgery along with copy of proof of identity.

If you live outside of our Practice Area and are registering as an Out Of Area patient we have enclosed a Health Questionnaire and some additional information explaining the conditions of registration and a number of key differences in the way some services would be delivered to you.

All forms must be completed accurately and signed; otherwise we will be unable to accept your registration.

The majority of our patients live more than a mile (or 1.6km) as the crow flies from a chemist or pharmacy and in this case we can dispense medication conveniently for you. Non-dispensing patients will collect a script to take to their chemist or pharmacy.

For patients requiring repeat medication there are a number of options available:

- Using our **website** www.leithhillpractice.co.uk just click on the "Order Repeat Prescription" button at the bottom of the home page on the left hand side and follow the instructions. Please ensure you tick the box on your registration to request this service.
- The **Dispensary Diary** - This allows patients who are on regular repeat medication to have their prescription prepared automatically
- Using the white re-ordering slip form your last prescription - **Hand in**, **Fax** or **Post.**
- If you are elderly or housebound, we offer a **telephone** service. This is available on:
  - ☎ The Old Forge Surgery 01306 713010 (between 12 noon and 4pm)
  - ☎ Northbrook Surgery 01306 889242 (between 8am and 1pm)

Please speak to one of our dispensing staff, who can advise which is the best re-ordering service for you.

Proof of identity:

- Passport
- Driving Licence
- Birth Certificate

Proof of Address:

- Current Utility Bill
- Current Bank Statement

THE LEITH HILL PRACTICE NEW PATIENT REGISTRATION

Patient's details: **Please complete in BLOCK CAPITALS and tick [√] as appropriate**

**** Please make sure all greyed out sections are completed ****

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Rev ☐ Other	Surname:
Date of Birth:	First Name:
NHS No:	Previous Surname/s:
☐ Male ☐ Female	Town and Country of Birth:
Home Address:	
	Postcode:
Tel Home:	Mobile/Work: Email:

IF YOU ARE REGISTERING A CHILD UNDER 16:

Mother's: First Name: Surname:

IF YOU ARE REGISTERING A CHILD UNDER 5:

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION:	
Your previous address in the UK:	Name of previous doctor while at that address:

IF YOU ARE FROM ABROAD:

Your first UK address where registered with a GP:

Name of GP whilst living at that address:

If previously registered in UK, date of leaving:	Date you first came to live in UK:

IF YOU ARE RETURNING FROM THE ARMED FORCES:

Address before enlisting:

Service or Personnel number:	Enlistment date:

ETHNIC GROUP:

White: ☐ British ☐ Irish ☐ Other	If Other please specify:
Black: ☐ Caribbean ☐ African ☐ Other	If Other please specify:
Asian: ☐ Indian ☐ Pakistani ☐ Chinese ☐ Other	If Other please specify:

Mixed: ☐ White + Black Caribbean ☐ White + Black African ☐ White + Asian ☐ Other

If Other please specify:

IF YOU NEED YOUR DOCTOR TO DISPENSE MEDICINES AND APPLIANCES:

☐ I live more than 1 mile in a straight line from the nearest chemist

DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS? ☐ **Yes** ☐ **No**

If yes: ☐ **Sign Language** ☐ **Large Print** ☐ **Other**

DO YOU REQUIRE ACCESS TO OUR ONLINE APPOINTMENT BOOKING AND REPEAT MEDICATION REQUESTING SERVICE (SYSTMONLINE)?

☐ **Yes** ☐ **No** If yes, you must provide your email address (on previous page).

Please contact the surgery if you do not receive a verification email within 10 days.

GENERAL DATA PROTECTION REGULATION (GDPR)

The security of patient data is our priority, we respect privacy and work hard to meet strict regulatory requirements. In line with the new regulations, we have recently updated our Privacy Notices. Please ask at Reception if you wish to see them in detail.

CARERS:

Do you have a carer? (If yes please give details) ☐ Yes ☐ No

Are you a carer? (If yes please give details) ☐ Yes ☐ No

If you answer yes to above: name of person you care for / relationship:

NHS ORGAN DONOR REGISTRATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death (Please tick as appropriate)

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of the body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register at Reception

NHS BLOOD DONOR REGISTRATION

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register at Reception

Signature of patient **Signature on behalf of patient** **Date**

NEW PATIENT SCREENING QUESTIONNAIRE FOR ADULTS

**** Please make sure all greyed out sections are completed ****

YOUR DETAILS:	
Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Rev ☐ Other	Surname:
Date of Birth:	First Names:

INFORMATION ABOUT YOU:
What is your height?
What is your weight?
What is your first language?
Do you need an interpreter? ☐ Yes ☐ No

SMOKING:	
Do you smoke?	☐ Yes ☐ No
If 'No', have you ever smoked?	☐ Yes ☐ No
Date you approximately gave up:	
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?	
If you would like advice and support to stop smoking, please make an appointment with the nurse for a smoking cessation appointment.	

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more

How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily

How often during the last year have you found that you were not able to stop	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily

drinking once you had started?					

How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily

How often in 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/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/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/Almost daily

Have you or someone else been injured as a result of your drinking?	No		Yes but not in the past year		Yes, during the past year

Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the past year		Yes, during the past year

Signature:	**Date:**

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....