Like us on Facebook to keep up to date with the latest health campaigns and practice news. Alternatively log on to www.longlanesurgery.com to find our more information on our practice.

Please complete and return this NEW PATIENT questionnaire together with 2 forms of identification.

Form 1 – medical card or passport or photo driving licence or national identity card. Form 2 – bank/building society statement or utility bill (less than 3 months old).

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)	Email address

*Do you consent to receive the following from Long Lane surgery: SMS text messages **Yes / No**
Emails **Yes / No** Answering machine messages **Yes / No**

*Do you consent to share information about the care you have received in different NHS organisations for approved research and with organisations outside of the NHS? (Care.Data) Yes / No

***Do you consent to consent to share your records with other Healthcare professionals(District Nurses, Community Health Nurses etc) on systm1? (Electronic Data Sharing Module) Yes / No**

Previous address and doctors details

*Previous address in the UK Postcode	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	*If previously a resident in the UK, date of leaving *Date you first came to live in the UK if applicable

If you are returning from the Armed Forces

Address before enlisting	Service or Personnel No. Enlistment date

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 my body ☐

Signature confirming consent to organ donation

_____ **Date:** _____

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.

Have given blood in the last 3 year YES / NO

Preferred address for donation (if different from above, e.g place of work) . _____

PTO

***Additional details For/About you:**

Important Information on your summary and your health record

A Summary Care record is information on any medicines you are taking or allergies you have. This information is currently available to authorised emergency health care staff providing you care anywhere in England as you have automatically been included in the scheme.

If you do not wish want a Summary Care Record it is important that you tell us. - Please tick the box below **- No, I do not want a Summary Ce Record** ☐

Take a note of your Accountable GP

We are now required to provide all of our newly registered patients information on who their named GP. Dr **Mayes** will have overall responsibility for the care and support that our surgery provides to you. This does not prevent you from seeing any GP in the practice as you currently do. You do not need to take any further action, but if you have any questions, please ask our reception team for further information.

We offer **Electronic Prescribing** for you convenience

What does this mean for you? You will not have to visit the practice to pick up your paper prescription. Instead, we will send it electronically to the place you choose, saving you time. You will have more choice about where to get your medicines from because they can be collected from a pharmacy near to where you live, work or shop. Select where you want your GP to send your electronic prescription.

Name and Address of my nominated pharmacy:_____

What is your ethnic origin?		
British/Mixed British ☐	Irish ☐	Chinese ☐
White/Black Caribbean ☐	White/Asian ☐	White/Black African ☐
Indian/British Indian ☐	Pakistani/British Pakistani ☐	Bangladeshi/British Bangladeshi ☐
Caribbean ☐	African ☐	
Other Asian Background ☐	Other Black Background ☐	Other White Background ☐
Other (please specify)		
I do not wish to answer ☐		

What is your main spoken language?			
English ☐	Hindi ☐	Gujarati	☐
Bengali ☐	Punjabi ☐	Somali	☐
Urdu ☐	Arabic ☐	Polish	☐
Other:	I do not wish to answer ☐		
Do You require an interpreter? Yes ☐ No ☐			

Do you require communication support or a specific contact method?	
Uses Hearning Aid ☐	Prefers communication in writing ☐
Lip Speaker ☐	Prefers communication verbally ☐
Uses Sign Language ☐	Prefers communication by teleopne ☐
Uses text relay ☐	Prefers communication by email ☐
Other Please Specify: i.e –	

Next of Kin Details:
Address/Telephone Number _____

Do you care for somebody? **Yes / No**
(This does not include being a parent)

Do you require a carer to assist you? Yes / No
Contact details: _____

Do you have a named social worker? Yes / No
Contact details: _____

PTO

Are you taking regular Prescribed Medication?	*If yes, please state: Name/Strength/Dose Below* *1)* 2) 3 4) 5) 6) 7)
Do you have any allergies? Yes ☐ / No ☐	*If yes, please state:*
Have you had any adverse reactions to medicines or substances? Yes ☐ / No ☐	*If yes, please state:*

Smoking status:	
Current smoker ☐ Daily Consumption:	**If you are a current smoker – have you thought about stopping smoking recently?** ☐ **Yes** ☐ **No** **If you would like help please ask for details from reception or contact Stop on 0845 045 2828**
Ex-smoker ☐ Date Stopped	
Never smoked tobacco ☐	
Please provide an estimate of your:	Height:
	Weight:

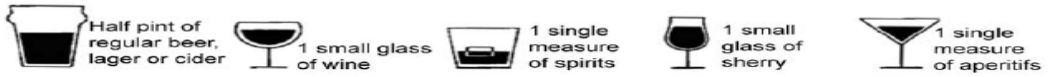
Previous Vaccinations (Please provide estimated dates)					
Diptheria	1st	2nd	3rd	Booster	Booster
Pertussis					
Tetanus					
Poliomyelitis					
Hib					
Pneumococcal					
Meningitis C					
MMR					
BCG					
Others (Please Specify)					

Do you or have you ever suffered from:									
Epilepsy		☐	Yes	Year		**Mental Illness**		☐	Yes	Year
High BP		☐	Yes	Year		**Diabetes**		☐	Yes	Year
Heart Attack / Angina		☐	Yes	Year		**Asthma**		☐	Yes	Year
Stroke / Mini-stroke (TIA)		☐	Yes	Year		**COPD (or Emphysema)**		☐	Yes	Year
Cancer		☐	Yes	Year		**Osteoporosis / Bone fractures**		☐	Yes	Year
Rheumatoid Arthritis		☐	Yes	Year		**Peripheral vascular disease**		☐	Yes	Year

WOMEN ONLY (Please complete)
Have you had a hysterectomy? **Yes No**
Have you had a cervical smear? **Yes No** If yes please give date: and result: **Normal** ☐ **Abnormal** ☐ **Don't know** ☐

PTO

This is one unit of alcohol… **EMIS NO:**



On average, please state how many units of alcohol would normally drink every week?

_____ Units per week.

AUDIT – C – Brief Alcohol Questionnaire:

	Scoring System = 0,1,2,3,4					
Questions	0	1	2	3	4	Your Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 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	
					Total Score	

Scoring: A total of 5+ indicates increasing or higher risk drinking. -

If you have scored 5+ Please complete the remaining questions below.

Remaining AUDIT questions:

Questions	0	1	2	3	4	Your Score
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during 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 or 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 or 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 or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total Score	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,16 – 19 Higher risk, 20+ Possible dependence

PTO

Application for SystmOnline

What is SystmOnline?
"SystmOnline" is a website which allows you to have access to our on-line services. These include: Arranging, checking and cancelling appointments, ordering medication, viewing your medical record

'Using on-line services could save you a trip, or phone call to the surgery.

You can use SystmOnline at home, at work or on the go 24/7 – where ever you can connect to the internet or alternatively Patient Access mobile app is free to download on Android and iOS.'

If you wish to have access to online services – please complete the details below.

Name: _____ Date of Birth _____

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

***Signature**	***Date**

For practice use only

Patient NHS number		Practice computer ID number
Address ☐ Photo ID ☐	Identity verified by (initials)	Enter Date:

Long Lane Surgery
Beacon House, Long Lane, Coalville, LE67 4DR

Online Services Records Access
Patient information leaflet

‘It’s your choice’

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.

Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.