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| photo | |  | | --- | | Dr. James Ogle  Dr. Reema Parwaiz  Dr. Zan Parwaiz  Dr. Paul Parwaiz | | |  | | --- | | icon  0116 2394960   icon [www.ratbysurgery.nhs.uk/](https://www.ratbysurgery.nhs.uk/)  icon  [Ratby.MedicalCentre@nhs.net](mailto:Ratby.MedicalCentre@nhs.net)  icon  [1A Desford Lane, Raby, Leicestershire, LE6 0LE](https://maps.google.com/?q=Ratby%20Medical%20Centre,%201A%20Desford%20Lane,%20Ratby,%20Leicestershire,%20LE6%200LE) | | |

Thank you for applying to join Ratby Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

**You MUST sign the form on the final page to confirm all the details given are correct.**

ALL INFORMATION GIVEN TO US WILL BE CONFIDENTIAL AND USED ONLY IN ACORDANCE WITH STATUTORY REGULATIONS e.g. Data Protection Act / GDPR etc

If you need any support in completing this form, please ask at the reception. If you have a disability, which means you need information in a different way please contact the surgery and fill in an Accessibility Contact Form.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Fields marked with an asterix (\*) are mandatory.

**PLEASE NOTE: IF YOU ARE REGISTERING AND LIVE AT AN ADDRESS OUTSIDE OUR CATCHMENT AREA**

**THE DOCTORS WILL NOT BE ABLE TO PROVIDE HOME VISITS.**

**IF YOU ALSO DO NOT ATTEND FOR THE REQUIRED MEDICATION CHECKS OR REQUIRED MONITORING, WE RESERVE THE RIGHT TO ASK YOU TO REGISTER WITH A LOCAL PRACTICE UNDER BREAKDOWN OF DOCTOR-PATIENT RELATIONSHIP \***

Please tick to confirm you have read this.

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| \*Title | \*First names |  | \* Any previous surname(s) |
| \*Surname | |  | Town and country of birth |
| What is your gender identity?  \*Male Female  Non-binary Prefer not to say  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you identify as transgender?  Yes No  Prefer not to say  \*What sex were you assigned at birth?  Male Female  Intersex Prefer not to say | |  | What are your preferred pronouns?  He / him / his  She / her / hers  They / them / theirs  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What is your sexual orientation?  Heterosexual (straight)  Homosexual  Bisexual  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*NHS No.  (if known) |
| \*Date of Birth | |  | \*Home address |
| \*Home telephone No. | |  |  |
| \*Mobile No. (if you have one) | |  | Email address:   |  |  | | --- | --- | | \*Main spoken languages | | | **English** | | | **Other** (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Interpreter required? | | | Yes | No | |
| Occupation: | |
| Marital status:  Single  Co-habiting  Married  Divorced  Civil partnership  Widowed  Separated | |
| |  | | --- | | Would you agree to the Practice sending you text reminders? \* Yes No  If YES you MUST advise the practice if your mobile number changes or it is no longer in your possession  I consent to the practice contacting me by text message and / or email for the purpose of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time. Text messages are generated using secure facilities, but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however, the practice will not transmit information which would enable an individual patient to be identified.    Answering machine messages\*  Yes  No |  |  | | --- | | Do you have any additional communication needs? Yes No  Please state your requirements………………………………………..……………………………………………..……………………………  ……………………………………………………………………………………………………………………………………………………………………..  We have a hearing loop – please ask at reception for details |  |  | | --- | | Previous address and doctors details…………………………………………………………………………………………………………  ……………………………………………..……………………………………………………………………………………………………………………… | | | | |

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| **Additional details about you**  \*What is your ethnic group? (Choose an option that best describe your ethnic group or background) | | | | | | |
| **White**  **Black**  **Asian**  **Mixed** |  | English/Welsh/Scottish  Caribbean  Indian  White + Black |  | Northern Irish  African  Pakistani  White + African |  | Irish Other  please specify)  Other \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  Chinese  White+Asian |

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| Are you a military veteran? Yes No  Do you know your…  **\*** Weight**……………………………… \***Height**…………………………………..** |

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| **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.  **(If under 16 must be answered by parent / guardian)**   1. Express consent for medication, allergies and adverse reactions only 2. Express consent for medication. Allergies, reactions and additional information\* 3. Express dissent – I do not want a summary care record   \* Additional information would give doctors access to your records should you need to attend another health care provider e.g. hospitals, A+E which could prove invaluable in case of an emergency. |

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| Do **you have** a Carer? Yes No  If yes, what is their name and contact number?  Do you consent for your carer to be informed about your medical care? Yes No |

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| Are **you** a Carer? Yes No  If yes, what is their name? ……………………………………………………………………………………………………………………………  If yes, do you look after someone who is a patient of Ratby Surgery? Yes No  Don’t know  If no what is the name of the GP surgery they are registered with…………………………………………………………………  ……………………………………………………………………………………………………………………………………………………………………….  Are they a: Relative Friend Neighbour Other  VASL are a team within Leicestershire who offer support for carers such as providing online support, telephone advice line and online directory of local services for carers, carer’s support groups and a telephone befriending scheme etc. <https://www.supportforcarers.org/> OR contact: 01858 468 543 |

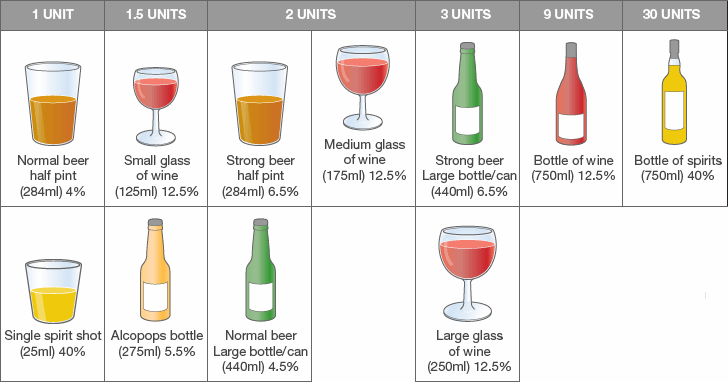
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| Are you an adult with social care involvement? Yes No  If yes, please state why? |

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| Do you have a nominated patient advocate / advocacy service or Lasting Power of Attorney? Yes No  If yes, which type and what are the details?.......................................................................................................  ………………………………………………………………………………………………………………………………………………………………………. |

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| Name of next of kin:  Relationship to you:  Next of kin telephone number(s)  Next of kin address (if different to above) |
| **DOMESTIC ABUSE: If domestic abuse is affecting your health you can speak to someone here.**  **Please tick this box if you would like a GP to contact you** |

**Please tell us about your alcohol consumption**

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| **Questions** (please circle your answers) | **Unit scoring system** | | | | |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never  (go to Page 4) | 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 |
| 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 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 you cut down? | No |  | Yes, but not in the last yea |  | Yes, during the last year |

**How many units of**

**alcohol per week?**

**……………………………….**

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| Medical details (Please list any medications including HRT and contraception) |

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| \*Are you allergic to any medicines?  Yes  No (if yes please specify below) |

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| **Looked after Children**  Are you looking after someone else’s child?  Yes  No  If Yes, under what arrangements:  Section 20-Voluntary Care  Interim Care Order  Care Order  Child arrangement order/Residence Order  Special Guardianship order  Placed for adoption  Private arrangement/Private Fostering/informal arrangement  (please note you have a duty to notify social care of this arrangement) | **Please tell us about your smoking habits**  Do you smoke?  Never  Ex-smoker  Smoker  If Yes, what do you primarily smoke:  Pipe  Cigarettes  Cigar  Other  Vape  How many do you smoke a day?  **Should you wish to quite please:**  **Call 0345 646 66 66** or visit **www.quitready.co.uk** |

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| **Please record any additional information about you that you think is important for us to know**  (Additional information includes: Social worker involved with your family; legal parental responsibilities of minor under 16 years old; applicant is in foster care or is adopted; if you are from overseas and claiming asylum or are a refugee) |

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| **You can register for online services**. This would give you access to booking appointments, ordering repeat prescriptions, viewing any blood test results etc. Would you like this? \*Yes No  If you wish to access your medical record online please read and tick the following statements to show you agree with each statement:   1. I will be responsible for the security of my login and password. 2. I will be responsible for the security of the information I see and 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.   1. If I see information in my record that is not about me, or is inaccurate, I will log out immediately   and contact the practice as soon as possible, |

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

**Thank you for providing this information. We look forward to providing you with high standard of care in a friendly and professional manner.**