Brandon Surgery Dr R Kapur & Partner
Belgrave Health Centre
52 Brandon Street
Leicester
LE4 6AW
Tel: 0116 2955000
Fax: 0116 2955002

NEW PATIENT REGISTRATION / HEALTH QUESTIONNAIRE

If you need any support in completing this form, please ask at the reception

Thank you for applying to join **Brandon Surgery Dr R Kapur** We would like to gather some information about you and ask that you fill in the following questionnaire in addition to the GMS1 form. 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.

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

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 Postcode	*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 Postcode	Service or Personnel No. Enlistment date

Teaching & Training Practice

Our practice is a teaching and training practice. You may be seen by a Medical Student or a GP Registrar or there maybe students present during your consultations with the clinicians. Please let the reception know when you come in for your appointment if you do not wish to have the presence of students during your consultation.

Please tick if you would like to have a medical student present **Yes** ☐ **No** ☐

Additional details about you

*What is your ethnic group? (Choose an 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*:				

*Main spoken languages

☐ **English**

☐ **Other** (please specify)

Interpreter required?

☐ Yes ☐ No

* Which of the following best describes you?

Bisexual	☐	Transgender gender reassignment patient	☐
Male homosexual	☐	Transgender gender identity disorder	☐
Female homosexual	☐		
Hetrosexual	☐		

*Do you have a Disability? ☐Yes ☐No

If yes, please tell us how we can support your need:

* Do you have a communication need that is related to your disability? ☐Yes ☐No

If you have answered yes, please tells us what communication need you have:

☐ Use hearing loop	☐ Use lip speaker	☐ Use hearing aid
☐ Use British Sign Language	☐ Use cued speech cued transiliteraor	☐ Use alternative communication skill
☐ Use Makaton Sign Language	☐ Use deaf-blind intervener	☐ Use Sign Language
☐ Use text phone	☐ Use communication device	☐ Use manual note taker
☐ Use speech to text reporter	☐ Personal Communication Passport	
☐ Other	If Other, please tell us how we can support your communication need:	

*Do you require information in a preferred format? ☐Yes ☐No (Choose below)

If you have another specific communication need please specify:

☐ Requires contact by telephone	☐ Requires contact by email	☐ Requires contact by text relay
☐ Requires contact by letter	☐ Requires information in Makaton	☐ Requires information in braille
☐ Requires information in large font	☐ Requires information in EasyRead	☐ Medicine labelling large print
☐ Requires audible alert	☐ Requires visual alert	☐ Requires tactile alert
☐ Requires communication partner	☐ Deafblind communicator guide	☐ Face the client communicating
☐ Interpreter needed -BSL	☐ Deafblind telephone user	☐ Other, please tell us:

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**

Tick this box if wish to opt-out of the SCR ☐

*Do you consent to receive the following types of communication from Dr R Kapur Surgery

Email	☐Yes	☐No
Mobile phone text messages	☐Yes	☐No
Answering machine messages	☐Yes	☐No

Medical Interoperability Gateway (MIG)

Whilst the SCR mentioned above 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.
For more information, please visit our website at - brandonsurgeryatbelgravehc.co.uk

Tick this box if you wish to opt-out of the MIG ☐

Risk Stratification Preferences
Risk Stratification patient data is shared between primary care and secondary care NHS providers and only when consent has been given at the point of care. **For more information please visit our website at** brandonsurgeryatbelgravehc.co.uk

Tick this box if you wish to opt-out of the Risk Stratification patient data use ☐

Electronic Data Sharing Module (EDSM)
Healthcare places can usually share information from your records by letter, email, fax or phone but this can slow down your treatment or mean information is hard to access. However you can choose to share your record electronically between care services. **For more information please visit our website at** www.drgandechasurgery.co.uk

Tick this box if you wish to opt-out of the EDSM ☐

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

Are you a Carer? ☐Yes ☐No
If yes, do you look after someone who is a patient of Dr R Kapur Suregery ☐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)

Medical details

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

*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)

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child

Who has the legal responsibility for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

Who can consent for the medical treatment for the child?

☐ You as the legal parent or guardian

☐ **Other** (please specify)

_____

Looked after Children

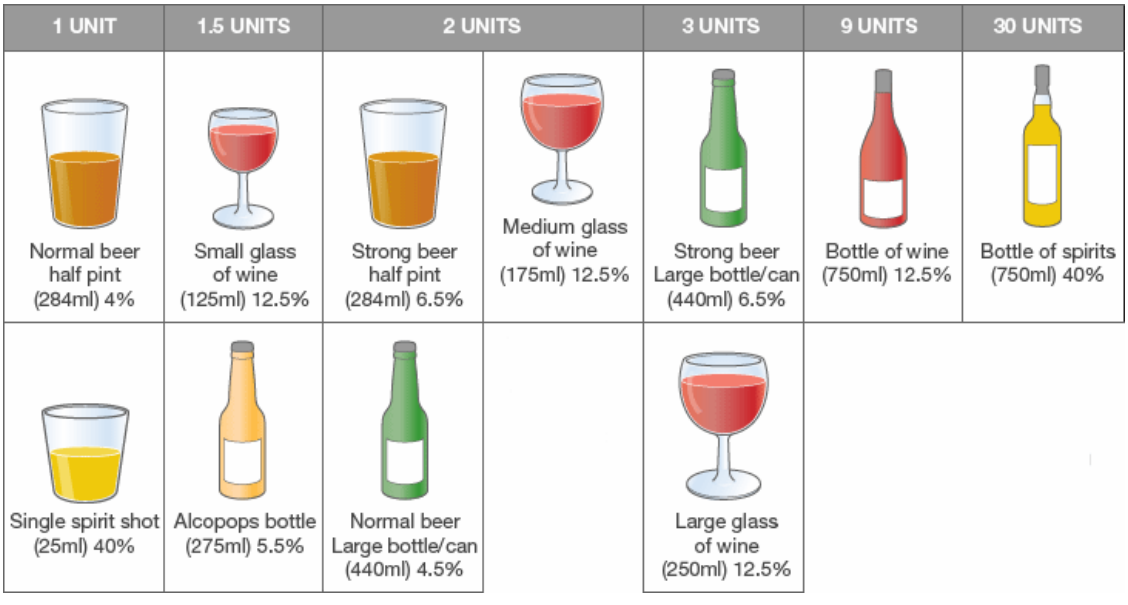
Are you looking after someone else's child? ☐ Yes ☐ No
If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order
☐ Child arrangement order/Residence Order ☐ Special Guardianship order
☐ Placed for adoption
☐ Private arrangement/Private Fostering/informal arrangement
(please note you have a duty to notify social care of this arrangement)

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No
If Yes, what do you primarily smoke:
☐ Pipe ☐ Cigarettes ☐ Cigar ☐ Other
How many do you smoke a day? _____
Would you like advice on quitting?
☐ Yes ☐ No

Please tell us about your alcohol consumption

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	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 year		Yes, during the last year



Please provide information below if known

Height	ft	in
Weight	st	lb
Waist measurement	in	

(**for women aged 25 to 64**) Have you had a cervical smear test?

☐ Yes ☐ No

If Yes Please state where, when and the result(if known)

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)

NHS Organ Donor Registration

"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…

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

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

***Signed**

***Date** (dd/mm/yyyy) **/ /**

Signed on behalf of patient (*if applicable*)
(Minors under 16 years old, adults lacking capacity)

Full Name:

Relationship:

On-line services

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our **on-line service** provider (System One) and access appointments, prescriptions and some sections of your own medical record via the internet. All of the details that you need for this are available on our practice website at - www.drgandechasurgery.co.uk on the 'appointments' and 'prescriptions' icons on the home page.

New Patient Health-check

You may be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you would like to take this up (Recommended).

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

Please take a copy of our practice leaflet.

FOR OFFICE USE ONLY

PHOTO ID/Birth Certificate (Over 18 only)	☐	**TYPE:** _____
ADDRESS ID	☐	**TYPE:** _____
Other	☐	**TYPE:** _____

BRANDON SURGERY DR R KAPUR
DR R KAPUR, M.B.B.S.; F.R.C.S. (Glas); M. S (Orth) F.R.C.S Ed; M. Ch (Ortho); M.R.C.G.P
Belgrave Health Centre
52 Brandon Street
Leicester
LE4 6AW
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Patient Online: Registration Form
Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

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

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing my medical record	☐

Application for online access to my medical record

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

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

Signature		Date	<Today's date>

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			
Date passphrase sent			