STUDENT PAPER REG FORM

DE MONTFORT SURGERY STUDENT PATIENT REGISTRATION FORM

NHS Number:

PATIENT DETAILS

Male / Female	Title: Mr/Mrs/Miss/Ms/Dr/Other……	Student / Non Student / DMU Staff

Surname:	Previous Surname:
First Names:	Date of Birth:
Leicester Address:- Room Number: Flat Number: Hall: Road: Post Code:	Town + Country of Birth: Mobile: …… Home: …… Email: ……..
Previous home address:	Name and telephone number of next of kin:
Registered GP whilst at above address:	If you have recently moved to the UK please state date of entry:

MEDICAL INFO

Do you suffer from any existing medical conditions?	Significant Past Medical History: Family Medical History (please state family member and condition.)
Are you on any current medication?	Any known allergies (please specify)

Have you had any previous mental health problems?

*Do you have a Disability? ☐ Yes ☐ No

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

…….....

* 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:

ADMINISTRATION INFO

*What is your ethnic group?
(Choose an option that best describes your ethnic group or background)

White:	☐ English/Welsh/Scottish	☐ North 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

Are you a carer?

Do you have a carer?

Please give any other relevant information:

……

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between Health care organisations such as hospitals or out of hours.

For further information please visit our website www.demontfortsurgery.co.uk

Tick this box if you wish to OPT OUT of SCR ☐

Medical Interoperability Gateway (MIG)

MIG shares a much fuller view of your records but only with the local NHS providers and only when you give explicit consent at the point of care with another health service.

For further information on MIG please visit our website www.demontfortsurgery.co.uk

Tick this box if you wish to OPT OUT of 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 Practice website

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 www.demontfortsurgery.co.uk

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

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)

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 / guardian
☐ Other (please specify)

……

Who can consent for the medical treatment for the child?
☐ You as the legal parent / guardian
☐ Other (please specify)

HEALTH CHECK: Are you between 40-74 years old?

If you answered yes to the above please book your free NHS Health Check with our health care assistant.

Please note that it is your responsibility to ensure your contact details are correct and you acknowledge this by signing this application form to register with De Montfort Surgery.

By giving us your mobile number you are agreeing to the surgery contacting you via text message.

Signature: ……

Date: ……

NHS blood/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 Circle)

Kidneys Heart Liver Corneas Lungs Pancreas
Any Body Part

Signature confirming consent to organ donation

……

I would like to join the NHS blood donor register as someone who may be contacted to donate blood. **Yes** or **No** (please circle.)

Have you donated blood in the last 3 years? **Yes** or **No** (Please circle)

LIFESTYLE INFO

Height: ……

Weight: ……..

Exercise: None / Some / 3 times a week

Smoking: Current / Ex / Never smoked

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	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 year		Yes, during the last year