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 REGISTRATION 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.

SUMMARY CARE RECORD (SCR)

An SCR is an electronic record that provides healthcare staff with rapid access to essential information about an individual in order to provide them with direct care and treatment.

If you do **not** wish to have an SCR please tick this box ☐.

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

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**

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