

**Sandy Lane Surgery**  
**Sandy Lane, Leyland PR25 2EB**  
**Phone: 01772 214 700**

---

**New Patient Registration**

**About you**

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname: ..... Forename(s): .....

Date of Birth (dd/mm/yyyy): .....

NHS Number.....

Gender: .....

**Preferred title**

Preferred title for official correspondence?.....

**Contact Information**

Address:.....

Telephone: ..... Mobile: .....

Email: .....

Please circle below your preferred choice of contact:

**Text    Phone (mobile)    Phone (Home)    Email    Post**

Do you live in a residential/nursing home? **Yes** ☐ **No** ☐

What is your occupation?.....

---

**Residency**

Previous address in the UK (if applicable):.....

If you are from abroad, what date did you come to UK?.....

Do you live in an EEA country?.....

---

### **Service Families and Military Veterans**

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

<b>I AM</b> a Military Veteran		<b>I AM</b> currently serving in the Reserve Forces	
<b>I AM</b> married/civil partnership to a serving member of the Regular/Reserve Armed Forces		<b>I AM</b> married/civil partnership to a Military Veteran	
<b>I AM</b> under 18 and my parent(s) are serving member(s) of the armed forces.		<b>I AM</b> under 18 and my parent(s) are veteran(s) of the armed forces.	

---

### **Ethnicity**

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

---

### **Religious affiliation**

Do you have a religious affiliation (please give details if so)?.....

---

### **Country of birth**

In which country were you born?.....

---

### **Main language**

Which is your main language?.....

Do you speak English?.....

Do you need an interpreter?.....

---

### **Specific contact requirements**

Do require contact in a specific format (e.g. due to blindness, deafness or other impairment)?

If so, please give details: .....

---

### **Carer status**

Do you have a carer? Yes ☐ No ☐

If Yes, please give details of their name, relationship and whether they are a patient here too.....

Are you yourself a carer? Yes ☐ No ☐

---

### **Next of kin**

Surname: ..... Forename(s): .....

Gender: .....

### **Emergency contact Information (for next of kin)**

Telephone: ..... Mobile: .....

---

## **Contacting you**

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Do you consent to the Surgery sending letters to your home address?    **Yes** ☐    **No** ☐

Do you consent to the Surgery sending text messages to your mobile?    **Yes** ☐    **No** ☐

Do you consent to the Surgery sending messages to you by email?    **Yes** ☐    **No** ☐

Do you consent to the Surgery leaving messages on your phone?    **Yes** ☐    **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

**Do you have a preferred method of contact?**

.....

Are you interested in joining our Patient Participation Group (PPG)?    **Yes** ☐    **No** ☐

---

## **Summary Care Record**

### **Summary Care Record (SCR)**

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

**For more information:** Phone 0300 123 3020 or visit [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk)

I do not wish to have a Summary care Record  
(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

**I wish to opt out of SCR** ☐

## **Electronic Prescribing Service (EPS)**

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this, we would encourage all patients to opt for electronic prescribing.

☐

**I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐

**I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy.....

Address.....

Postcode.....

---

## **Donation wishes**

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.

If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit:

<https://ardens.live/Organ-donation-opt-out>

Do you have a donor card or are you on the organ donation register?      **Yes** ☐      **No** ☐

Have you opted out?      **Yes** ☐      **No** ☐

Do you donate blood?      **Yes** ☐      **No** ☐

---

## **Resuscitation wishes and Power of Attorney**

Do you have a DNACPR (Do not attempt CPR) form in place?      **Yes** ☐      **No** ☐

Does anybody hold Lasting Power of Attorney for Health and Welfare for you?      **Yes** ☐      **No** ☐

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).

Details.....

---

## **Smoking status**

Do you smoke?      **Yes** ☐      **No** ☐

If **yes**, how many cigarettes do you smoke daily: .....

If **no**, have you smoked in the past?      **Yes** ☐      **No** ☐

Do you use electronic cigarettes/vape?      **Yes** ☐      **No** ☐

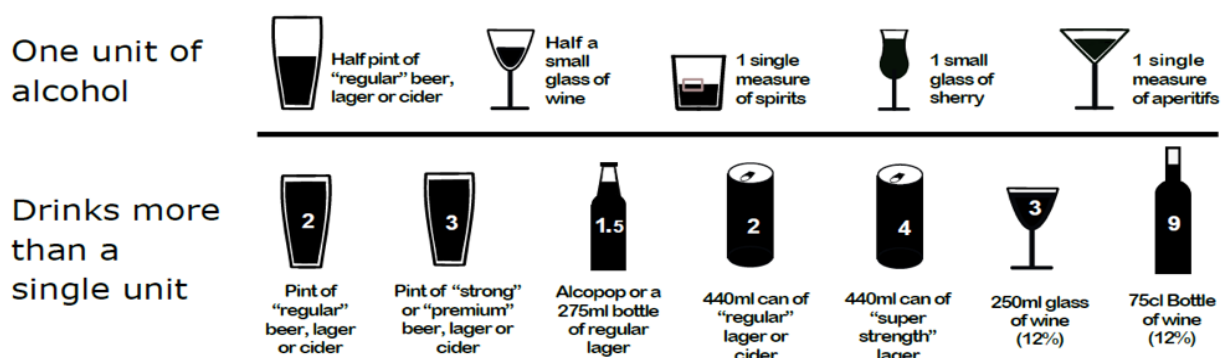
Smoking is the UK's single greatest cause of preventable illness

Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription.

If you would like help and advice on how to give up smoking, please contact <https://www.quit4life.nhs.uk/> or ask at reception.

## Alcohol intake

### Alcohol unit reference



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

### Scoring

Score: .....

A total of 5+ indicates increasing or higher risk drinking. If you have a score of 5+ please complete the remaining questions below.

Questions	Scoring system					Your score
	0	1	2	3	4	
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	

Questions	Scoring system					Your score
	0	1	2	3	4	
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	

Please add up your scores from the above tables and write the total below:

**Total**.....

If you would like help and advice on how to reduce your alcohol intake, please contact <https://www.drinkaware.co.uk/> or ask at reception.

## Exercise

### General Practice Physical Activity Questionnaire

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the last week, how many hours did you spend on each of the following activities? Please answer whether you are in employment or not

Please mark one box only on each row

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace  
(i.e. less than 3


Steady average pace


mph)

Brisk pace

Fast pace  
(i.e. over 4mph)

### Height/Weight

What is your height: .....

What is your weight:.....

If you would like advice on managing a healthy weight, please contact <https://www.nhs.uk/live-well/> or reception who will be able to direct you to the most appropriate service.

### Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs?

Yes ☐ No ☐

If yes, please state your needs below:

.....

Do you have significant mobility issues?

Yes ☐ No ☐

If yes, are you housebound?

Yes ☐ No ☐

(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)

Are you blind/partially sighted?

Yes ☐ No ☐



Do you have significant problems with your hearing?

Yes ☐ No ☐

---

### **Transfusion history**

Did you have a blood transfusion before 1991?

Yes ☐ No ☐

---

### **Family History and past medical history**

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

<u>Condition</u>	<u>Yes</u>	<u>No</u>
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

<b>Condition</b>	<b>Year diagnosed</b>	<b>Ongoing?</b>

### **Allergies**

Please list any drug or food allergies that you have:

.....  
.....  
.....

### **Medications**

Please provide a list of repeat medications:

.....  
.....  
.....

---

### **For female patients only**

Are you currently pregnant?

Yes ☐ No ☐

**If yes**, please ensure you are under the care of a midwife. If you're not currently under the care of a midwife please speak to reception regarding this.

Which method of contraception (if any) are you using at present?

.....

Do you currently have long acting reversible contraception in place? (*Implant/Coil*)

Yes ☐ No ☐

If **yes**, when was this fitted? (dd/mm/yy)

.....  
Have you had a cervical smear test?

Yes ☐ No ☐

If **yes**, when was this last done? (dd/mm/yy)

.....

Have you had a hysterectomy?

Yes ☐ No ☐

Do you still have your ovaries?

Yes ☐ No ☐

---

### Non-Attendance of Appointments

There are increasing pressures upon all doctors and nurses to reduce waiting times and increase patient access.

Sadly, **a number of appointments are wasted each week** due to patients **not** giving us notice that they would not be attending appointments. In addition, nursing and administrative time is wasted where records and/or equipment needs advance preparation.

**We would appreciate it, if you know you cannot attend an appointment, that you cancel it as early as possible.**

We will continue to monitor missed appointments. Persistent failure to either cancel or attend may result in removal from our list.

### Zero Tolerance

Our practice staff are here to help you. Our aim is to be as polite and helpful as possible to ALL patients.

If you consider that you have been treated unfairly or inappropriately please ask the reception team to contact a member of the management team who will be happy to address your concerns.

However, shouting and swearing at practice staff will NOT be tolerated under ANY circumstances and patients who are abusive may be removed from the practice list.

Please help us to help you

Please tick to confirm you have read and understand the above and will comply ☐

## Patient Access Information Leaflet

GP Online Services allow you to access a range of services via your **PC, mobile phone** or **tablet**.

You can still contact the practice by phone or in person.

Being able to see your record online will help you to manage your medical conditions better, whenever you need. It also means that you can access your details from anywhere in the world should you require medical treatment.

You can close your account at any time. This decision will not affect the quality of your care.

You will only be able to see appointments on the system if there are any available to book at that time.

### **To Register:**

You must have an email address unique to you.

You must complete and sign the registration form.

You must have your identity verified by one of our staff.

### **Verifying your identity**

If you are well known to the surgery we may be able to do this by "verbal verification" by asking you questions about your health record. If you are not well known to the surgery or a new patient you will need to bring in some form of photographic identification.

If you do not have identification or you cannot get to the surgery because of serious health problems talk to us - we can still help you register.

Once you have been given or emailed your registration letter you must use it to register on your devices.

If you are using a **PC** type this address in your browser <https://www.patientaccess.com/>

Click on **REGISTER** put in our postcode **PR25 2EB** and off you go!

Once you have completed registration you simply just sign in with your email and password.

It will be your responsibility to keep your login details and password safe and secure. If you suspect that your record has been accessed by someone without your permission, then you should change your password immediately. If you are having any problems firstly contact the support centre within Patient Access.

If you are still having problems after contacting them contact the surgery on 01772 214690 or email [ann.walker3@nhs.net](mailto:ann.walker3@nhs.net) (please note that this department is not manned 24/7.)

## **Things to consider before you register**

### **Forgotten history**

There may be something you see in your records that you have forgotten and may upset you.

### **Abnormal blood results or bad news**

If you have been granted access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

### **Misunderstood information**

Your medical record is designed to be used by clinical professionals to ensure you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification please contact the surgery for a clearer explanation rather than googling!

### **Information about someone else**

If you spot anything in your medical record that is not about you or is an error, please contact the surgery ASAP.

### **Printing hospital letters or other information**

If you print out any information from your record, it is also your responsibility to keep this secure. If you do not have a secure place to store printed information, we would advise against printing any.

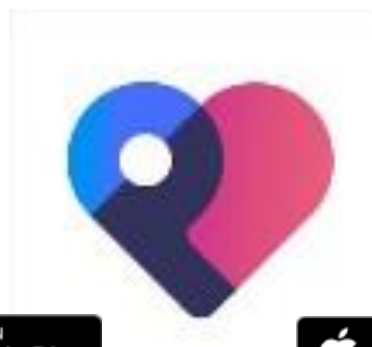
### **Choosing to share your information with someone**

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

### **Coercion**

If you think you may be pressured into revealing details from your patient record to someone against your will, it is best that you do not register for access at this time.

**\*\*PLEASE NOTE: Your application may take up to a month to be processed\*\***



## Application form for online access to the practice online services

Surname: Surname		Date of birth: Date of Birth	
First name: Given Name			
Address: Home Full Address (stacked)			
Email address: Patient E-mail Address			
Telephone number: Patient Home Telephone		Mobile number: Patient Mobile Telephone	
Registering for patient access will allow you to: book appointments, request repeat prescriptions and view your medical record. You will automatically be given access to all data added to your records that is entered from the date your application is processed. <b>If you would like access to past data please tick this box.</b> <input type="checkbox"/>			
I wish to access my medical record online and understand and agree with each statement (tick)			
I have read and agree to the information given on the information leaflet provided.			<input type="checkbox"/>
I will be responsible for the security of the information that I see or download			<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk			<input type="checkbox"/>
If I suspect that my account has been accessed by someone without my agreement I will contact the Practice as soon as possible			<input type="checkbox"/>
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			<input type="checkbox"/>
If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.			<input type="checkbox"/>
Sensitive information may be redacted from my record and I understand this.			<input type="checkbox"/>
Signature			Date:

<b>For Receptionist's use only</b>			
EMIS ID number: EMIS Number			
Identity verified by: (Signature):	Method used	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/>	
Evidence provided:			Date:

<b>For Administrator's use only</b>	
Contraindications on record:	Date:

<b>For Clinician's use only</b>	
Level of record access granted: Full Access <input type="checkbox"/> Partial Access <input type="checkbox"/>	If only partial access granted, please detail the access the patient should be given and why this decision has been made:
Date access granted by clinician:	Granted by (signature):

# Redaction Suggestion Form

## FOR STAFF USE ONLY

Redaction Suggestion	GP Confirmation (Please tick if to be redacted)


**GP OR ANP SIGNATURE NEEDED**

Signed by :

Date:

\_\_\_\_\_