Lingwell Croft Surgery

NHS

Dear New Patient

Welcome to Lingwell Croft Surgery.

Thank you for choosing our GP Practice.

We are delighted that you are joining our friendly, local practice and hope that you find it offers all you need.
We have 10 Doctors, 3 Advanced Nurse Practitioners, a nursing team of 9, and a Pharmacy team of 3.

In addition we have a strong administration team of highly experienced receptionists and secretaries. Everyone works hard as a team to ensure the smooth running of the Practice and the best experience possible for you when you are unwell.

Please find enclosed a Registration form, a New Patient Questionnaire and health form for you to complete.

Once you have registered please ask at reception for your login details so that you can order your repeat prescription and access your medical records **online**. Ask the receptionist for further details.

Our opening times are as follows:

Monday and Tuesdays	8.30am to 8pm
Wednesday and Thursday	8.30am to 6pm
Friday	7.30am to 6pm

For further details about our appointment system please ask the receptionist for a leaflet "Accessing our appointment system".

Please note we offer appointments at the weekend through the Extended Access Team from 9am till 3pm on a Saturday and Sunday. Please call the surgery number on the weekend if you need to be seen, and you will be transferred to them. For medical assistance outside these hours please contact NHS111.

If you have any suggestions or comments – we would be delighted to hear them!

Kind regards

Lingwell Croft Surgery

16 Shelldrake Drive, Middleton, Leeds, LS10 3NB
Tel: 0113 270 4848 / 270 5372 Fax: 0113 272 0030
Email: info.lingwellcroft@nhs.net Website: www.lingwellcroft.co.uk

New Patient Assessment

Surname: ______________________

First Name(s): ______________________

Address ______________________

____

____

____

Ethnicity (please tick)

Bangladeshi	☐	Pakistani	☐
Black – African	☐	White	☐
Black – Caribbean	☐	Other (state below)	☐
Chinese	☐	______________	
Indian		Patient refused	☐

Telephone – Please tick preferred contact number, preferably where you can be contacted during surgery hours. (8:30am – 6:00pm).

☐ Home: ______________ ☐ Work: ______________ ☐ Mobile: ______________

Receiving SMS Text reminders from the surgery.
Please tick the box if you **DO NOT CONSENT** ☐ (if the box is left blank we will assume consent)

Main spoken language ______________________

Gender: (please tick) Male (including trans men) ☐ Female (including trans women) ☐
Non-binary ☐ Other ☐
Is this the gender you were assigned at birth? Yes ☐ No ☐
Sexual orientation: Heterosexual or Straight ☐ Lesbian or Gay ☐ Bisexual ☐

Other (please specify) ______________
Date of Birth: ______________ **Occupation:** ______________
Email Address: ______________________
Next of Kin Name: ______________________
Relationship: ______________ Contact No: ______________

Family History: Tick appropriate boxes and write in which relative has had the illness.

☐ Heart Attack: ______________
☐ Diabetes: ______________
☐ Asthma: ______________
☐ Stroke: ______________
☐ Cancer: ______________
☐ High Blood Pressure: ______________
☐ Tuberculosis: ______________
☐ Other serious illness: ______________

Do you have, or have you had in the last three months, any illness, operations, x-rays or similar tests?
If so please give details:
____

Medication: Are you on any medication?

Name: ______________ Dose: ______________
Name: ______________ Dose: ______________
Name: ______________ Dose: ______________
Name: ______________ Dose: ______________
Name: ______________ Dose: ______________
Name: ______________ Dose: ______________

Allergies Do you have any allergies? ______________________
Registered Pharmacy : Kamsons ☐ Midway ☐ Boots, Middleton ☐ Belle Isle Pharmacy ☐ Other:
____

Register for online service ☐

Please note - if you require this service an email address must be filled in above.

Smoking Status:

Current Smoker ☐ Amount per day: ____________

E-cigarette Smoker ☐

Quit Smoking ☐ Date: ____________

Never Smoked ☐

If you are a current smoker would you like to speak to a smoking cessation advisor? YES ☐ NO ☐

Alcohol Intake: How many units per week: ____________

(½ pint of normal beer / lager = 1 unit, small glass (125ml) of wine or measure of spirit = 1½ units)

Female Patients ONLY:

How many children? ☐ Give ages: ____________________

Have you had a miscarriage? ☐ Date: ____________________

Have you had a termination? ☐ Date: ____________________

Have you had a hysterectomy? ☐ Date: ____________________

Are you using contraception? ☐ Which: ____________________

If registering a child please fill in the following information:

Mother's name: _________________________ DoB: ____________________

Father's name: _________________________ DoB: ____________________

Child's main carer name (i.e. who the child lives with): _________________________

Current / Proposed school or nursery: _________________________ Dates: ______________

Immunisation history: ____

Name of Health Visitor: ____

Social Worker (if appropriate): ____

Who is allowed access to the child's medical records? (i.e. if parents are separated, etc.)

Name: _________________________________ Relationship: _________________________

Name: _________________________________ Relationship: _________________________

Name: _________________________________ Relationship: _________________________

If you care for someone else please fill in the following information:

I look after my (please state relationship, e.g. mother, father, son or daughter, neighbour, friend).

____

Why they need your care (please give reason, e.g. elderly, housebound, illness – give details).

____

Is the person you care for registered at Lingwell Croft Surgery? **YES*** ☐ **NO** ☐

*If **YES,** and the person you care for consents, please provide their name and date of birth.

Name: _________________________________ DOB: _________________________

We are keen as a Practice to support you with both your medical care & if you are struggling because of a non-medical problem. We have some specialists in the area that can help if you would like some support? Yes ☐ No ☐

Is the problem relating to: Debt ☐ Housing ☐ Benefits ☐ Loneliness ☐ Diet ☐ wanting to learn new skills? ☐ Digital support ☐ Other ☐

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☐ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous GP practice while at that address

Address of previous GP practice

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: .... Enlistment date: Discharge date: (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient**

Date / /

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

062021_006 Product Code: **GMS1**

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name .... Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name Date ___/___/___

Practice Stamp

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

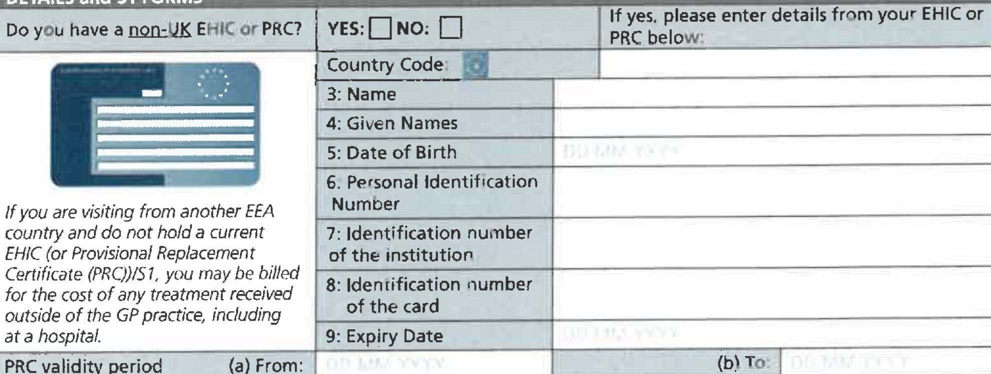
c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in an EU country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.



NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with Business Service Authority for the purpose of recovering your NHS costs from your home country.

NHS

Request for all clinical data to be withheld from the summary care record.

Please return this form to your participating GP practice

To be completed by the individual (data subject) making the request.
Please complete in BLOCK CAPITALS.

Title

Surname / Family name

Forename(s)

Address

Postcode

Tel No

Date of birth

NHS number (if known)

What does it mean if I DO NOT have a summary care record?
Health-care staff treating you may not be aware of your current medications in order to treat you safely and effectively.

Health-care staff treating you may not be made aware of current conditions and/or diagnoses leading to a delay or missed opportunity for correct treatment.

Health-care staff may not be aware of any allergies/adverse reactions to medications and may prescribe or administer a drug/treatment with adverse consequences.

If you have any questions, or if you wish to discuss your choices or concerns, please telephone the NHS Care Records Service Information Line on 0845 603 8510.

If you remain unsure about whether or not to have a SCR please contact your participating practice.

Signature

Date

Actioned by practice:

Date:

4479 (Mar 2010)

Name:	
Date of Birth:	
If you do not want to supply this information, please tick this box	☐

Alcohol unit reference

One unit of alcohol

Half pint of "regular" beer, lager or cider

Half a small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

Drinks more than a single unit

Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or cider

440ml can of "super strength" lager

250ml glass of wine (12%)

75cl Bottle of wine (12%)

Fast alcohol screening test (FAST)

FAST is an alcohol harm assessment tool. It consists of a subset of questions from the full alcohol use disorders identification test (AUDIT). FAST was developed for use in emergency departments, but can be used in a variety of health and social care settings.

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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	
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	
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	

FAST score	

An overall total score of 3 or more on the first or all 4 questions is FAST positive.

What to do next?

If your score is FAST positive, complete remaining AUDIT alcohol screening questions; this may include the three remaining questions above as well as the six questions on the second page to obtain a full AUDIT score.

Remaining alcohol harm assessment questions from AUDIT

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 8	10 or more	
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 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	
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	

Total AUDIT score	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk,
- 20 or more indicates possible dependence

If you have any concerns or are worried about your drinking habits, please make an appointment to see Roger Clegg, (Substance Misuse Worker) from Forward Leeds through reception.