WELCOME TO THE PRACTICE

COMMUNITY HEALTH CENTRE (Leicester Medicare Ltd)

The Practice offers online services such as:

Registration Forms, Repeat prescriptions and appointments (to access these services you will need to be over 18 years of age and must be registered at the practice. Please ask at the reception for further details).

Surgery opening times :

The Practice is open Monday to Friday from 8am – 6.30pm. Extended Hours are held on Mondays and Fridays from 6.30pm – 8.30pm.

Should you require an appointment please call the surgery on 0116 2622946 at 8am for all (morning and afternoon) appointments.

For minor illness ailments, such as cough and colds, flu fever, please access your local pharmacy in the first instance.

The practice operates a strict DNA Policy (missed appointments) if you are unable to attend your appointment please call the surgery at least 24 hours in advance to cancel your appointment.

Clinician Availability

The Practice has 3 Female GP's and 4 Male GP's

1 Female Practice Nurse and 1 Male Practice Nurse

2 Health Care Assistants (1 Female and 1 Male)

Disabled Access

The surgery is able to accommodate wheelchair users.

Patients that are hard of hearing we offer a hearing loop at reception.

Should you require further details about our Practice please ask at Reception for a Practice Leaflet.

THANK YOU

THIS PRACTICE OPERATES A ZERO TOLERANCE POLICY WE WILL NOT ACCEPT PHYSICAL OR VERBAL ABUSE

REGISTRATION I.D.

FRAUD PREVENTION

For all new registrations or changes to your personal details we will require proof of I.D. and proof of address.

- Passports with Current VISA Status + any of the of the following:-
- Home Office Letter / Solicitors Letter if no Passport
- Birth Certificate (Required for new born babies)
- Marriage Certificate (If changing current surname)
- Driving Licence – Photo card licence (provisional not accepted)
- Deed Poll Certificate (change of name)

With any of the above you must also attach the following:

- Current Utility Bill or Bank Statement (within the last 3 months).
- Repeat Medication Slip (if you are taking regular meds)
- PHOTOCOPIES OF VACCINE/IMMUNISATION RECORD for children and adults aged 0-25 years

YOU MUST PROVIDE THE ORIGINAL AS WELL AS PHOTOCOPIES OF THE ABOVE DOCUMENTS, STAFF WILL NOT BE EXPECTED TO CARRY OUT ANY PHOTOCOPYING.

Please note failure to provide any of the above information could delay your registration process.

ALL THE FORMS MUST BE READ, SIGNED AND COMPLETED. ANY INCOMPLETE REGISTRATIONS WILL NOT BE PROCESSED. THANK YOU.

If you are homeless or an asylum seeker then there are specific surgeries in the area that are available to support you which are listed below.

Asylum Seeker - Clyde Street Practice,1a Clyde Street, Leicester LE1 2BG

Phone: 0116 295 2400

Homeless – Charles Berry House, 45 East Bond Street, Leicester, LE1 4EX,

Phone: 0116 221 2780

Community Health Centre

Melbourne Centre

Melbourne Road

LE2 0GU

Patient Online: Identity Verification

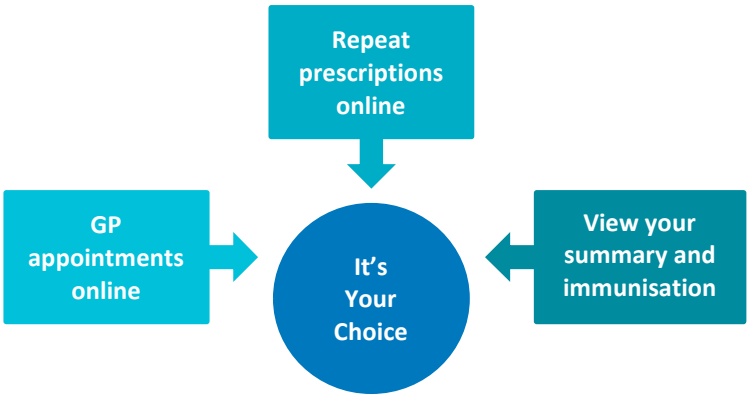
Example practice protocol

Appointments	Any patient registered with the practice may book an appointment 'slot' online at any time by completing the system's online registration process. This does not require verification of the applicant's identity.
Identity verification and registration for online services	Before services in addition to online appointment booking are enabled, the patient's identity must be verified either by vouching or presentation of appropriate documents (see Cabinet Office Good Practice Guide No. 45 (2013)). Ordering of repeat prescriptions, appointment booking and demographics are enabled by the practice when each patient is registered for online access following identity verification.
Presentation of documents	Two documents need to be presented when a patient's identity is verified, at least one of which should contain a photo of the individual. The documents should be checked for consistency, and the applicant compared to the image on the photo ID. Any two of the following three documents are acceptable: passport, driving licence, bank statement. Alternatives should be checked against the government approved list of acceptable documents.
Recording of identity evidence	Identity verification follows legal, professional and ethical standards. The name of the person verifying an applicant's identity, the method used and date should be recorded in the patient's records. This can be achieved by scanning in the completed application form.

Patient Online: Records Access

Patient information leaflet 'It's your choice'

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical summary and immunisations online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.



Being able to see your summary online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. In general this decision will not affect the quality of your care.

You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

More information

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:

Keeping your online health and social care records safe and secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf

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 doctor while at that address

Address of previous doctor

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

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

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

If you need your doctor to dispense medicines*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

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

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

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

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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 _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

PLEASE COMPLETE THIS FORM AS PART OF YOUR REGISTRATION.

PART 1 – Personal Information

Title Mr/Mrs/Miss/Ms/Other Please State _____

Surname _____ Forename _____

Home Tel No _____ Mobile No _____
(Please ensure you give your mobile number as the Practice will send out important SMS to your mobile phone).

Email Address: _____

Ethnic Origin _____ Next of Kin _____

If from overseas, the date did you enter the UK ____/_____/____ (Make sure you have attached a photocopy of your visa and passport).

Are you disabled? Yes ☐ No ☐

Are you a Registered Carer for a family member? Yes ☐ No ☐
(Registered carer if you are receiving carers' allowance)

If yes who do you care for elderly /disabled?

_____

First Language Spoken _____

Can you speak English? Yes ☐ No ☐

Do you require an Interpreter? Yes ☐ No ☐

If yes which language? _____

Your Previous Address _____

…….. Post Code _____

Are you aware of any family members or friends that work at this surgery? Yes ☐ No ☐

If yes please state name and relationship:

Name	**Relationship**

What is your sexual orientation? Heterosexual ☐ Gay/Lesbian☐ Bisexual ☐ Prefer not to say ☐

What is gender Identity? Cisgender (gender identity same as biological gender) ☐ Transgender ☐ Prefer not to say ☐

PLEASE MOVE TO PART 2 OF THE REGISTRATION FORM

PART 2 – Your Health Information

Height (in metres) _____

Weight: (KG_____

Do you drink alcohol? Yes ☐ No ☐

If yes how many glasses/pints per week? _____

Do you smoke? Yes ☐ No ☐ If yes than how many? _____

Please state any Allergies _____

Do you suffer from any of the following long term illnesses?

Diabetes Mellitus	Yes ☐ No ☐
Hypertension / High Blood Pressure	Yes ☐ No ☐
Angina **OR** Previous Heart Disease	Yes ☐ No ☐
COPD / Chronic Lung Disease/ Asthma	Yes ☐ No ☐

If any other long term illness please specify

_____

_____

Do you take regular medicines? Yes ☐ No ☐

If 'Yes' please attach your copy of repeat medicines.
(If you do not have a copy of your repeat medications, please obtain from your previous GP and attach with this form)

Do you wish to give consent for others to collect your prescription on your behalf? Yes ☐ No ☐
If yes please complete the prescription consent form attached.

Would you like to have a HIV Blood Test (Blood Borne and Sexually transmitted virus)?
Yes ☐ No ☐
(For more information about HIV testing you can pick up a HIV Leaflet from the leaflet dispensers within the surgery, or visit http://www.cmft.nhs.uk/directorates/mcsh/documents/HIV.pdf)

NOTICE TO ALL PATIENTS:

As per our Practice Policy, we will not issue Prescriptions for Over the Counter Medications (OTC).

These include: Paracetamol, Ibuprofen, Sudocream, E45, Emollients for dry skin, Vitamins, Cough Medicine, Colic drops and other items you can buy over the counter from chemists and supermarkets.

Practice Copy – Please sign and give back to Practice

PART 3 – Rights and Responsibilities

GP/ Patient Charter - Please ensure that you have read and agreed to the Patient Charter.

Patient's rights

As a patient you have the right to:

A) Be registered with a named doctor

B) Expect to be contacted by any GP as a minimum within 2 – 7 days and that it is **not** a guarantee that you will be seen on the same day.

C) In order to achieve the above, you could receive a telephone consultation for minor or ongoing conditions, and be seen by the GP only **if they decide** you should be seen as a result of the telephone consultation.

D) Change doctor if desired (but please remember that you may have to see any of the doctors **if your need is urgent or an emergency**)

E) Receive emergency care if it is deemed appropriate.

F) Receive appropriate drugs and medicines

G) Be referred for specialist or second opinion if you and GP agree

H) See your medical records or a copy, **subject to certain laws**

I) Know that by law, everyone working for the NHS must keep the contents of your medical records private.

Patient's responsibilities

With these rights come responsibilities for the public. That means being:

A) Courteous to staff at all times, and recognise that the practice operates a NHS Zero Tolerance policy. Any verbal or physical abuse or use of aggression may result in your registration with the practice being cancelled.

B) As prompt as possible for all appointments **(you may not be seen if you are over 10 mins late, and it will be at the clinician's discretion)**

C) Responsible for cancelling appointments in adequate time **(if you do not inform us then you will be regarded as missing the appointment. If you miss 3 appointments within a 6 month period, we reserve the right to remove you from our list. You will not be allowed to rejoin for 6 months.)**

PLEASE NOTE THAT IF YOU CHANGE YOUR ADDRESS AND MOVE OUT OF THE PRACTICE BOUNDARY YOU WILL BE REQUIRED TO FIND ANOTHER DOCTOR.

Signed _____

PRINT (name) _____

PLEASE MAKE SURE YOU HAVE COMPLETED ALL THE QUESTIONS AS IT MAY RESULT IN DELAYING YOUR REGISTRATION. THANK YOU

Date _____

12 Practice Copy

Community Health Centre
Melbourne Centre
Melbourne Road
LE2 0GU

Tel: 0116 262 2946
Fax: 0116 242 2049

Consent Form

Patients Date of Birth …… /…… /……..

Patients Address……..

Contact Details……..

I (name of patient) …… give the following person(s) (only up to 2 people to give consent):

Full Name	Relation to patient	Contact Details	Please tick if this is your Carer

Please tick each box that applies:

1. Consent to discuss any issues regarding medical conditions with the doctor ☐
2. To request and obtain medical letters, medical records, summary and sick notes on my behalf ☐
3. Obtain test results ☐
4. Collect or Request prescriptions on my behalf ☐
5. Collect username and passwords for my online access ☐

Patients signature ……..

Date …… / …… / ……

IF YOU DO NOT WISH TO DISCUSS ANY INFORMATION AS ABOVE TO ANY FAMILY MEMBERS PLEASE TICK HERE ☐

Application for online access to my medical record

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

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my summary and immunisation records	☐

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

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. Children under 16 years of age parents can have access unless a GP deems it is of detriment to the patient	

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐		Notes / explanation	

Limited parts ☐ Contractual minimum ☐	