

PRESTON ROAD SURGERY

56 Preston Road, HA9 8LB, Wembley
Tel: 020 8904 6442 Email: breccg.preston56@nhs.net

Registration Times:

Call queries: 12:30pm-1:00pm

Walk in: Mon-Fri: 1.30pm -2.30pm or
4pm -6pm.

New Patient Registration

Date of Application:

Section 1: About you

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

Date of birth (dd/mm/yy):.....

Gender:.....

NHS number (required if this isn't your first surgery):.....

Children Under 5

A copy of your childhood Immunisations needs to be scanned and sent to the provided email address.
If you are not from the UK, please receive a copy from your native country of your immunisations.

Section 2: Contact Information

Address:.....

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

Email:

Please circle below your preferred choice of contact:

Text ☐ Phone ☐ Email ☐ Post ☐

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

What is your occupation?.....

Section 3: 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).

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Section 4: Medical Questionnaire

Name:

Please tick if you have any of the following medical conditions to treat you in the timeliest manner and update your medical records

Diabetes	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Chronic Heart Disease	<input type="checkbox"/>
Chronic Obstruction of Pulmonary Disorder COPD			<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>		
Stroke & TIA	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Learning Difficulties	<input type="checkbox"/>	Chronic kidney disease	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>		

Any psychological issues

Any safeguarding issues in the past

Substance misuse

History of violence

Any other diseases:

I confirm that I do not have any of the above medical conditions. ☐

.....

.....

Signature

Date

Section 5: Free TB Screening (Eligibility form)

This form will help determine if you are eligible for a FREE TB test. For more information on the TB programme please see www.thetruthabouttb.org/latent-tb

Please complete ALL questions, unless you have circled No to questions 2 or 3.

1. Please write your country of birth?
2. Have you lived in the UK for less than 5 years? Yes / No (Please circle)
3. Have you lived in any of the below countries for 6 months or more? Yes / No (Please circle)
4. Are you between the ages of 16-35? Yes / No (Please circle)

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(If you have answered **Yes** to **Questions 2 and 4 or 3 and 4**, please continue, if you have answered **No** to any of the above questions you **do not** have to complete the rest of this form.)

5. Are you from/ did you move to UK from one of the following countries, **listed below**?
Yes / No (Please circle).

Country	Country	Country	Country
Afghanistan	DR Congo	Lesotho	Papua New Guinea
Angola	Djibouti	Liberia	Philippines
Bangladesh	Equatorial Guinea	Madagascar	Republic of Moldova
Benin	Eritrea	Malawi	Rwanda
Bhutan	Ethiopia	Mali	Sao Tome and Principe
Botswana	Gabon	Marshall Islands	Senegal
Burkina Faso	Gambia	Mauritania	Seychelles
Burundi	Ghana	Mauritius	Sierra Leone
Cote d'Ivoire	Greenland	Micronesia	Somalia
Cabo Verde	Guinea (Republic of)	Moldova	South Africa
Cambodia	Guinea-Bissau	Mongolia	South Sudan
Cameroon	Haiti	Mozambique	Swaziland
Central African Republic	India	Myanmar (Burma)	Timor-Leste
Chad	Indonesia	Namibia	Togo
Comoros	Kenya	Nepal	Tuvalu
Congo	Kiribati	Niger	Uganda
DRP Korea	Laos PDR	Nigeria	Uganda
		Pakistan	Tanzania
			Zambia
			Zimbabwe

6. If you were born in one of the countries above:

Do you have a bad cough? Yes .../ No ... ;

Do you sweat a lot at night? Yes.../ No ...

Have you lost a lot of weight in the last year? Yes.../ No ...

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Office use only

If patient has answered **yes** to questions 2 & 4 or 3 & 4 and has circled one of the countries in the table the patient is eligible for TB screening. Please offer the patient a blood test (IGRA) to see if they are at risk of Tuberculosis (TB) .

If the person said Yes to any of the questions in (5) please make an urgent appointment to be screened for active TB

FAO receptionist: If patient is eligible for TB screening, please mark on the top of this form “**patient is eligible for LTBI Screening**” and hand form to registrations person so patient can be scheduled for a blood test ASAP. **FAO: Registration Person**, please use the ‘born in read code’ for the country circled above.

Section 6: Patient Online Registration

Please register to use the NHS App. It will allow you to request medication, nominate pharmacies for prescriptions, integrate with eConsult and send secure messages to the practice.



- 1) Download the NHS app on your computer, tablet or phone
- 2) Follow the steps on the link to register: <https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/help/nhs-login/>

Documents & Medication required for registration:

- 1) All questions need to be completed, and documents attached for you to be registered
- 2) Please email breccg.preston56@nhs.net the scanned copies of:
 - ID: Passport, Birth Certificate, HC2 Certificate, Rough sleepers’ identity badge, Hostel Registration
 - Proof of Address: e.g. utility/ electricity bill, bank statement (within the last 3 months), tenancy agreement
 - **For children under 5:** Passport or birth certificate, Red book (including front page and immunisations)
- 3) Please bring your current regular medications (with the boxes) when you attend the New Patient Health Check.

Office Use only

Mode of registration: online In person

Registration taken by: Date :

Form checked : Yes No form

Registration completed by: Date :

Data entered to patient’s notes: Y No by Date: