# 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: DD MM YY Discharge date: DD MM YY (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*

**Not all doctors are authorised to dispense medicines*

☐ 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

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

Date_____/_____/_____

### 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

***Signature confirming my consent to join the NHS Organ Donor Register*** **Date** _____/_____/_____

*Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.*

### 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 my consent to join the NHS Blood Donor Register*** **Date** _____/_____/_____

*My preferred address for donation is: (only if different from above, e.g. your place of work)*

Postcode:

*All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.*

**NHS England use only** Patient registered for ☐ GMS ☐ Dispensing

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## 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*

Practice Stamp

*Authorised Signature*

Name

Date _____/_____/_____

**SUPPLEMENTARY QUESTIONS 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 another EEA 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 | | |
| | 9: Expiry Date | DD MM YYYY | |
| PRC validity period (a) From: | DD MM YYYY | (b) To: | DD MM YYYY |

*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.*

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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

THE GUILDHALL & BARROW SURGERY

# New Patient Registration Form

Thank you for choosing to register with The Guildhall & Barrow Surgery.

Please fully complete this questionnaire, writing clearly and in **BLOCK CAPITALS**. If you require any assistance, please speak to Reception.

In order to speed up the registration process, please provide Reception with photographic ID and evidence of your address (such as a utility bill) at the time of handing in your registration forms **if these documents are available**. If you do not have these documents, you are still able to register with our Practice.

| | | |
|---|---|---|
| **Full Name:** | | **Date of Birth:** |
| **Address:**<br><br>**Postcode:** | | |
| **Home Phone Number:** | **Mobile Phone Number:** | **Work Phone Number:** |
| **Email Address:** | | |
| **Consent to contact you via email:**<br>**Yes** ☐ **No** ☐ | | **Consent to contact you via text message:**<br>**Yes** ☐ **No** ☐ |
| **NHS Number:** | | **Place of Birth:** |
| **Height:** | | **Weight:** |
| **If over 40, please provide a recent blood pressure reading:** | | |
| **Relationship Status:** | | **Occupation:** |
| **Ethnicity:** | | |
| **Main spoken language:** | | **Translator required?**<br>**Yes** ☐ **No** ☐ |
| **Do you have any communication, or building access needs?**<br>**Yes** ☐ **No** ☐ | | **If yes, please provide details to reception** |
| **Next of Kin Name and Address:** | | **Relationship to you:**<br><br>**Contact Telephone Number:** |
| **Are you a carer?**<br>**Yes** ☐ **No** ☐ | If you spend time looking after a relative, child, partner or friend who is disabled or has a mental health difficulty, you are a carer | |
| **Does someone care for you?**<br>**Yes** ☐ **No** ☐ | **If yes, who cares for you?** | |
| **Are you housebound?**<br>**Yes** ☐ **No** ☐ | **Would you like to hear from other organisations that can support you? Yes** ☐ **No** ☐ | |

THE GUILDHALL & BARROW SURGERY

**MEDICAL HISTORY**

| **Please list any serious illnesses, operations, accidents etc.** | **Month/Year** |
|---|---|
| | |
| | |
| | |

**Are you currently taking any medicines?** **Yes** ☐ **No** ☐

If yes, please give details below:

| **Name of medicine** | **How often taken** | **Date started** |
|---|---|---|
| | | |
| | | |
| | | |

**Please indicate your nominated pharmacy for electronic prescriptions:**

**Address / location:**

**Do you suffer from:**

- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Heart Disease**
- ☐ **High Blood Pressure**
- ☐ **Any other condition which requires you to take life long medication**

.....

**Please list any allergies:**

**Family History -** Please tick if a close relative has suffered from any of the following conditions and indicate their relationship to you

| | | |
|---|---|---|
| **Diabetes** | ☐ | _____ |
| **Stroke** | ☐ | _____ |
| **Asthma** | ☐ | _____ |
| **Epilepsy** | ☐ | _____ |
| **Heart Disease under 60** | ☐ | _____ |
| **Cancer (please state type)** | ☐ | _____ |
| **High Blood Pressure** | ☐ | _____ |
| **Any other significant history** | ☐ | _____ |

**Do you have a 'Living Will' (a statement explaining what medical treatment you would not want in the future)?** *If yes, please provide a written copy for our records.*

**Yes** ☐ **No** ☐

**Please state the name and relationship of anybody you wish to speak on your behalf (i.e. a person with Power of Attorney):**

THE GUILDHALL & BARROW SURGERY

**Tobacco Use**

| | | | |
|---|---|---|---|
| **Never Smoked** | ☐ | | **Would you like to see a nurse to discuss smoking cessation?** |
| **Ex-Smoker** | ☐ | **Date stopped:** | |
| **Current Smoker** | ☐ | **Cigarettes _____/day** | |
| | | **Roll-ups/Pipe_____oz/week** | **Yes** ☐ |
| | | **Cigars _____/day** | **No** ☐ |

**Alcohol Use**

Alcohol intake units per week = _____ 1 unit = 1/2 pint of beer, 1 measure of spirit or a small glass of wine

| **Please circle the most appropriate answer to the following questions:** | | | | | |
|---|---|---|---|---|---|
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |
| 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 |
| 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 |
| 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 | |

THE GUILDHALL & BARROW SURGERY

**Females Only**

| | |
|---|---|
| Are you currently pregnant?<br>**Yes** ☐ **No** ☐ | If so, when is your due date? |
| Have you had a hysterectomy?<br>**Yes** ☐ **No** ☐ | If so, please say when: |
| If you are between 24 and 65, have you had a cervical smear?<br>**Yes** ☐ **No** ☐ | If so, when was the last one? |
| What is your current method of contraception? | |

## Patient Participation Group

The practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views and ideas for making services better. By expressing your interest, you will helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date developments within the practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you.

| | | |
|---|---|---|
| Yes I am interested in becoming involved in the PPG (please tick the 'Yes' box) | **Yes** | |

## Online Services Registration

**Reception can provide you with a username and password to enable you to book and cancel appointments, order medication and view a summary of your medical record. Should you wish to make use of this convenient service, please provide some photographic ID to reception.**

| | | |
|---|---|---|
| Yes, I am interested in using the online services (please tick the 'Yes' box) | **Yes** | |

**Consent To Hold Your Records**

The Practice needs to hold your medical records on the premises in order to give you the best medical care possible. We keep your records on the computer as well as holding paper notes. All of our patient's notes are covered by the Data Protection Act 1998. This means that a third party cannot access your records without your consent.

**Summary Care Record**

Your Summary Care record is an electronic record of important information about your health and is available to healthcare staff providing your NHS care in England, for example A&E. This means that if you ever become ill and need urgent or out of hours treatment outside of the surgery, the clinicians that treat you will have immediate access to important healthcare information about you. **If you do not want this to happen, please ask reception for an Opt-Out form**

| | |
|---|---|
| **Patient Signature:** | **Date:** |
| **Signature on behalf patient:** | **Relationship:** |

Thank you for completing this form

***For more information about the services we offer, please refer to the leaflets provided by reception or see our website: www.theguildhallsurgery.co.uk***

# Who can see my health record?

To treat you safely and well, it is important that professionals you see can access your health record.

Only by letting your GP surgery know it is ok will your notes be available to be seen by other professionals such as hospital clinicians, paramedics or district nurses.

## How do I make my record available to health professionals?

Simple. Complete this form and hand it into your GP surgery. There are two ways that this sharing can happen and it's important you understand what they are so you can make the right decision for you.

| **A. Summary Care Record with Additional Information** |
|---|
| A Summary Care Record has basic information on that is useful for NHS clinicians. It shows if you have allergies and it lists your medications. 98% of people have this. By including "Additional Information", this will add your illnesses and any health problems, vaccinations, operations and information on how you would like to be treated. |

| **B. Full Electronic Health Record** |
|---|
| Your full electronic health record is held by your GP surgery. It can also be made available to health and social care staff, if they are involved in your direct care. **Staff must still ask for your permission before they look at your record**. This also allows your surgery to see what other staff are doing to support and treat you. If there are certain parts of your record that you wish to keep private, your surgery can do this. |

## Does this mean anyone can just look at my record?

**No**. Your record can only be seen by staff who **are currently involved in your direct care, have a need to see it, and have asked for your permission**. The only exception to this is in case of an emergency. For instance, if you were taken to hospital unconscious, a doctor could look at your record without your permission. If this happens, a permanent alert is created showing who looked at the record and why.

## Are you going to sell the information in my record?

**Never**. If your record is shared, it's only ever available to staff for the purposes of your care, nothing else.

## Can I change my mind?

**Yes**. Just tell your surgery and they can update your decision at any time.

## *Your* decision to agree to either one, or both

| | | | Please Tick |
|---|---|---|---|
| **A** | Yes, I am happy for additional information to be added to my Summary Care Record, this means healthcare staff treating me can see a summary of my medical history in addition to my medication and allergies*. |  | |
| **B** | Yes, I am happy for my full health record to be shared by my GP surgery. This will be available to health and social care professionals who are currently treating me, and have my permission to view it. |  | |

**If you already have a basic summary care record and now wish to opt out of this completely, please ask your practice for an SCR consent form.*

**Name:** _____ **Date of Birth:** _____

**Signature:** _____ **Date:** _____

If you are filling in this form on behalf of another person, please ensure that you fill in their details above; you sign the form above and provide your details below:

**Name:** _____ ☐ Parent ☐ Legal Guardian ☐ Lasting power of attorney

***For more information** about the Summary Care Record and health record sharing, please refer to [www.bit.ly/whocanseemyrecord](www.bit.ly/whocanseemyrecord) or call PALS on 0800 389 6819.*

| **Information for GP Practices** | |
|---|---|
| A | To opt patient in to SCR with Additional Information, add read code **XaXbZ** (SystmOne) or **9Ndn** (EMIS) |
| B | For health record sharing: In SystmOne, choose "**Record Sharing**" and then "**Yes**" and "**Consent given**". In EMIS Web, choose "**Sharing**" from the **Care History** tab, "**EMIS Sharing Consent**" and choose "**Patient Consents**". |