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_____/_____/_____

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:

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

NEW PATIENT REGISTRATION AND INFORMATION PACK

Dear Sir/Madam

Please find enclosed a number of forms which need to be completed in full in order to register with the practice.

You will also find our practice leaflet and other useful information enclosed.

Once you have completed all of the forms, please return the entire form pack to Reception together with your identification documents to complete the registration process.

Thank you for choosing our practice.

Yours faithfully

Littlebury Medical Centre

Enclosed:

Form Pack -	Purple Registration Form
	New Patient Registration/Health Questionnaire
	ID Requirements for New Patients
	Summary Care Records Option Form
	SMS Consent Form
	Online Services Registration Form
Information -	Practice Leaflet
	SMS Services
	Online Services

ADMIN USE ONLY:

Pack received by: Staff Member Name _____

Date: _____

LITTLEBURY MEDICAL CENTRE

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:
To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Have you previously been registered at this practice, including as a temporary resident? Yes*/No

If yes, please advise of reason for leaving: _____

* Please note that we will be unable to register you permanently until your case has been discussed in our Clinical Meeting. You will be advised of the outcome after the meeting.

Surname: _____ Forename(s): _____

Date of Birth: _____ Marital Status: _____

Address including postcode:

_____

_____

_____

Home Telephone: _____ Mobile Telephone: _____

Email address: _____

National Health Service Number**: _____ Occupation: _____

** You will find this on your Medical Card or previous GP practice information

Weight (approximately): _____ Height: _____

Ethnic Origin: _____ Date of completion of this form: _____

SMOKING

Do you currently smoke? Yes/No

If yes, we offer a smoking cessation service in the practice. Please ask at Reception for further details

Have you ever smoked? Yes/No

If you currently smoke, how many

Cigarettes per day _____ Cigars per day _____ Grams of tobacco per day _____

How old were you when you started smoking? _____

EX SMOKERS

How old were you when you stopped smoking? _____

How much did you smoke per day? _____

PASSIVE SMOKING

Are you exposed to smoke at work? Yes/No

Are you exposed to smoke at home? Yes/No

ALCOHOL

MEN: How often do you have EIGHT or more drinks on one occasion, WOMEN: how often do you have SIX or more drinks on one occasion?	N/A 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?	N/A 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 of you because of drinking?	N/A Never Less than monthly Monthly Weekly Daily or almost daily
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	N/A No Yes on one occasion Yes on more than one occasion

DIET

Do you add salt to your food after cooking? Yes/No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No

Has your cholesterol been checked in the last 2 years Yes/No

EXERCISE

Do you take regular exercise? Yes/No

If yes, what sort of exercise? _____

How many times per week? _____

FAMILY HISTORY

Is there any of the following in your family (father, mother, brother, sister) before the age of 65?

Heart disease (heart attacks, angina) Yes/No

If yes, which family member? _____

Stroke? Yes/No

If yes, which family member? _____

Cancer? Yes/No

If yes, which family member? _____

Site of cancer? _____

MEDICATION

Give details of any medication which you take (prescribed or otherwise). Please provide a copy of your repeat medication slip from your previous surgery.

Name of drug:

Dosage:

Name of drug:

Dosage:

Name of drug:

Dosage:

ALLERGIES

Are you allergic to any substances or foods? Yes/No

If yes, please give details:

PAST MEDICAL HISTORY

Do you consider that you have any information or communication support needs relating to a disability, impairment or sensory loss? Yes/No

If yes, please explain how we can best meet your needs, eg information in large print or braille

Please give details of any hospital treatment as an in-patient:

Please give details of any treatment for any chronic medical conditions:

Please give dates of any x-ray, MRI or CT scans, Mammogram, Ultrasound

IMMUNISATIONS

Date of Triple/Polio/HIB

Dates of MMR

Date of last Tetanus

FOR CHILDREN ONLY: Please provide a copy of vaccination history. If this is unavailable, you will need to make an appointment to discuss vaccinations

CARERS

Do you need/have anyone who looks after you or your daily needs as a Carer? Yes/No

Do you care for anyone else? Yes/No

If yes, please provide details:

If yes, ask our Reception team about support for carers

Military Veterans

Are you a Military Veteran? Yes/No

Please provide your leaving date Date :

PHARMACY INFORMATION

Are you eligible to have your medications dispensed at the practice? Yes/No

Do you require us to dispense your medication if eligible? Yes/No

If you are not eligible to have your medications dispensed here, which pharmacy would you like any prescriptions sent to?

Any prescriptions you need will be sent directly to the pharmacy of your choice for collection

Thank you for completing this questionnaire. Your GP will assess the information provided and will invite you for an initial examination, discussion about your health and general check within the next few days if required.

SUMMARY CARE RECORDS

The NHS uses an electronic record called the Summary Care Record to support patient care. It is a copy of key information from your GP record and provides authorised healthcare staff with secure access to essential information about you when you need unplanned care or when the practice is closed. Summary Care Records improve the safety and quality of your care.

We need to know whether you wish to allow your details to be shared in this way.

Please tick **ONE** of the following options and return this form with your ID and registration documents.

☐ Consent for medication, allergies and adverse reactions only

☐ Consent for medication, allergies, adverse reactions and additional information

☐ I do not want a Summary Care Record

We will update your medical records with your decision. This can be changed at any time you wish.

Full name _____

Address _____

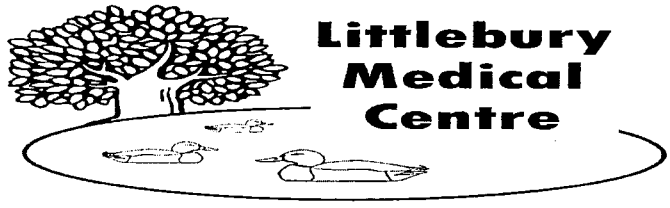
_____

Postcode _____

Date of Birth _____

Signed _____

Date _____



Patient Consent for Email and Text Message Communication

AGE 16+ ONLY

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and Littlebury Medical Centre would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting Littlebury Medical Centre.

Please complete this form and hand it in at reception if you consent to any, or all, of the above.

Patient Name _____ **Date of Birth** ...../...../.....

Mobile _____ **Consent to use?** **Y** **N**

Address _____ **Consent to use?** **Y** **N**

_____

Email _____

Signature _____ **Date** _____

Please confirm your consent to one (or more) of the following;

☐ **Text message reminders of forthcoming appointments**

☐ **Newsletters (and similar communications)**

You can grant consent to all the purposes of use, one of them or none of them. Where a patient does not grant consent then we will not be able to use their personal data to communicate with them in this way.

Littlebury Medical Centre

Application for SystmOnline Login ID and Password

Full Name	
Date of Birth (Age 16+ Only)	
Address	
Email address (mandatory to allow receipt of verification link)	

Please issue a password to enable me to access the SystmOnline website. I understand that this will grant me access to book appointments, request repeat prescriptions and view my summary medical information. If I wish to view my detailed medical record, I will ask at Reception for the consent form to do this.

I am aware of the following conditions:

- I accept responsibility for the password and any access to the system using the password.
- I am aware that if I divulge the password to other parties, they will be able to access information about me.
- I agree to inform the Practice immediately if I believe my password has been lost/stolen.
- The Practice may cancel my access (without notification) if there is abuse of the system such as:
    - Booking appointments and not attending.
    - Repeatedly booking and then cancelling appointments.
    - Repeatedly requesting prescriptions that I do not need.

You will need to produce photographic identification, eg Passport, Driving Licence, Photocard, Bus Pass before access can be granted. Please bring this with you when returning the form to us.

Signed	
Date	

For Practice Use:

ID Details:	
Member of staff	
Date Login ID & Password Given	

Please pass form for scanning

Littlebury Medical Centre
Fishpond Lane, Holbeach, Spalding, Lincolnshire, PE12 7DE

Dr A Sykes, MA, BM, BCh
Dr S Ajumal, MBBS, MS, D Urol, MRCGP, DFSRH, FMMC
Dr M Ibrahim, MD, MRCGP, DCH, DRCOG, DFSRH

General Enquiries: (01406) 422231
Appointments: (01406) 422054
Fax: (01406) 425008

ID REQUIREMENTS FOR NEW PATIENTS

Please could you return your completed registration form to Reception together with two pieces of identification proving your name and address. One piece of identification should be photographic.

Acceptable forms of identification are:

- Passport
- Driving Licence – photocard (and paper counterpart if available)
- Birth Certificate
- Medical Card
- Marriage Certificate
- Bank/Building Society statement
- Paid utility bill dated within the last 3 months
- National Insurance Card/Letter
- Payslip from your employer
- Letter from the Benefits Agency
- Papers from the Home Office
- Local Authority Rent card

ADMIN USE ONLY

Patient's Name: _____

Patient's Address: _____

_____

_____

Details of Photo ID seen: _____

Passport/Driving Licence Number: _____

Details of Address verification: _____

Input by - Staff Initials and Date _____