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

052019_006 Product Code: **GMS1**

Richmond Medical Centre
Patient Registration Form
(15 years and over)

In order to assist the practice with your care whilst we await your complete medical records from your previous practice – please complete this Confidential Form:

Surname..... Title ..... Date of Birth ….....

First name(s)..... Place of birth ……..…….....

Full address ……

…… Post code…….

Telephone..... Mobile.....……..

Emal: ……..

Have you been a member of the armed forces? Yes / No

If yes please provide enlistment date ……..….. and (if applicable) discharge date ……..

Next of kin .....Relationship .....

Next of kin's address ……..

……Contact Number: ……

Do you have a Carer? Yes / No Are you a Carer? Yes / No

Their relationship to you ……..….. Carer's contact no …….

Carers address: ……

Please advise of any disabilities you have: ……..

If you would like information regarding extra help as a Carer, please let reception know.

Medical Record Consent

Please give details below of anyone you wish to have full access to your medical records including test results and other confidential information.

Name: ……

DOB: ……. Tel Number: ……..

Relationship to Patient: ……

Signed: ……(by patient) Date: ……..

(*Should you wish to have more than one authorised person to have full access to your records please inform Reception who will give you another consent form to sign)*

IF NEW ARRIVAL INTO THE UK

DATE OF ARRIVAL

……

Eligibility to NHS Medical Services determined by reason of **(PLEASE TICK):**

☐ I am living in the UK lawfully and on a settled basis and have been resident/intend to reside for more than 6 months AND CAN PROVIDE EVIDENCE TO SUPPORT THIS.

☐ I am a student and can provide evidence of this (if so is the course government funded?– YES / NO)

If no, how long is the duration of the course? ……

☐ I am an EEA National coming to UK to Work/Study. I have valid E128 FORM

☐ *I am an asylum seeker*

SIGNED …….. DATE ……

Smoking

Are you a smoker Yes / No
If no, are you an ex-smoker Yes / No If no, what year did you stop? …….

Smokers:
How many cigarettes do you smoke a day? …….
How many cigars do you smoke a day? ……..

(We strongly recommend that you do not smoke and we offer appointments and leaflets to assist you to stop smoking).

Alcohol

It is a government priority to address the issue of illness associated with alcohol consumption. From 2008 GP practices a
required to record for all new patients aged over 16 the amount of alcohol consumed.
As you are registering at the practice, please complete the table below.
Dependent upon your score the practice may invite you for an appointment with the nursing team for a review.
If you do not wish to complete this form please sign here……..

Scoring
(please circle most relevant answer then use the score band 0 - 4 below to obtain your total score)

Questions	***0***	***1***	***2***	***3***	***4***	Your Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
How many alcoholic drinks do you have on a typical day?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Exercise

	Tick		**Tick**
Takes **heavy** exercise *(e.g.20 mins, 3 times a week more)*		Takes **light** exercise *(walk to shops, gardening etc.)*	
Takes **moderate** exercise *(e.g. brisk walks, 3 times a week)*		Exercise physically impossible	

What is your current **Height? ……..** What is your current **Weight? ……**
(Shoes removed) *(In light clothing)*

Ethnic Origin (Please circle)

White British. White other. Black Caribbean. Black African. Black, other with non-mixed origin. Indian. Pakistani. Bangladeshi. Chinese. Vietnamese. Other ethnic group with mixed origin. Other ethnic group.

Prescriptions

If you know you are allergic to any medications, please state here ……..
……
……

We are now using the Electronic Prescription Service (EPS) within our surgery. This enables GPs and practice nurses to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

Please state the name of the pharmacy you wish for your prescriptions to be sent to:

…….
(Please note from the day of your prescription request, your items will be ready directly at your nominated chemist after 48hrs)

Past medical history - Please write here details of anything you would like your doctor to know about your past medical history (in particular include if you have had angina, stroke, heart attack, high blood pressure, asthma or any operations). Please indicate above the medication you are taking for these conditions.

Year	Event

<u>Women only</u>

Have you had a cervical smear in the last 5 years? Yes / No / Unsure

If yes, do you know the date? ……

Patients Online Service – Book GP Appointments & Order Prescriptions

In order to help improve access to appointments and repeat prescription ordering, you can now book appointments online with any of our regular GP Team. You will be able to cancel and check appointments already booked.

You can also request repeat prescriptions.

This service is available at any time including outside the normal reception hours.

NAME …….

ADDRESS …….

…….....

…….

EMAIL ADDRESS ……

DATE OF BIRTH……
(Please note we are unable to issue passwords to parents, if the child is over 13 years. The child would need to sign the request)

DATE OF APPLICATION ……

Please issue a password to enable me to access the System On-Line website. 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 can 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.

To access this service, please bring in your photographic ID with the completed form.
For children under 13, please bring in the full birth certificate with the completed form.
(Please note a parent has to be registered for online services first)

Signed…….

For Surgery use:

Identification Produced ……

Member of Staff ……

Password Issued on (Date:) ……

……

TEXT MESSAGING CONSENT FORM

Name of Patient:	Date of Birth:
NHS Number:	Mobile Tel:

I would like to receive text messages to the above mobile telephone from Richmond Medical Centre and understand that the content may relate to any aspect of the medical record for the patient listed above only and may include confirmation of an appointment, details of test results, or a reminder alert.

Should I wish to withdraw consent I accept that I must give at least 5 working days notice in writing quoting the above mobile number. I will advise the practice if I change my mobile number and understand that a new consent form is required.

I am aware that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed.

Richmond Medical Centre NHS net email address will appear at the bottom of each text.

I confirm that I understand the above statement and that I am the patient listed above. I understand that it is my responsibility to advise the Richmond Medical Centre to stop sending texts to the telephone number listed.

Full Name: …….

Signature: ……..

PLEASE NOTE WE CANNOT DO TEXT MESSAGING FOR CHILDREN UNDER 16 YEARS OF AGE

ONE FORM PER PATIENT – CONSENT MUST BE SIGNED BY ACTUAL PATIENT

Patient Contact Waiver & Appointment System Acceptance

Routine Appointments

Routine appointments with a doctor may be booked up to two weeks in advance only.

If you need an urgent appointment you may be offered a same day appointment with the duty doctor. At particularly busy times your appointment may not be on time.

Patient Contact Waiver

In accordance with the Data Protection Act there is a requirement that Practice staff, when required to contact a patient on medical matters relating to the patient, can only speak to the person concerned. If anyone other than the patient answers the phone the member of staff cannot reveal who is calling. This undoubtedly causes frustration not just from a staff perspective but also delays the passing of any messages to the patient in question. This is particularly so in the case of communicating results.
In an effort to overcome this problem could you please indicate:

Are you happy if a message is left with a member of your household saying that you have received a call from Richmond Medical Centre? YES NO

Are you happy for a member of your household to take a message for you? YES NO

Are you happy for a message to be left on any answerphone you may have at your home address asking you to contact Richmond Medical Centre? YES NO

Are you happy for any message to be left via voicemail on any mobile number that is registered to you? YES NO

Are you happy for a message asking you to contact the practice to be sent via any email account you may have? This would include any family type email addresses that are registered at your home address and is used for email purposes by more than one family member? YES NO

In signing this statement I confirm that I understand the appointment system and that I have agreed to those options that I have circled above and recognise that this authorisation will remain in force for the duration of the time that I remain a patient at Richmond Medical Centre or until such time as I give notice that I wish to revoke any of the declarations that I have made above.

Name: …… Date of Birth: ……

Signature: …… Date: ……..

e-mail address: …….

SHARING YOUR INFORMATION NATIONALLY

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

We are supporting Summary Care Records and as a patient you have a choice:

- ☐ **Yes I would like a Summary Care Record** –a Summary Care Record will be created for you.

- ☐ **No I do not want a Summary Care Record – Please ask at Reception for an opt out form to complete.**

If you need more time to make your choice please let us know.

For more information talk to our Patient Advice and Liaison Service (PALS) on 0845 602 4384, visit the website **www.lincolnshire.nhs.uk** or **www.nhscarerecords.nhs.uk,** telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020 or ask a member of the practice staff.

Additional copies of the opt out form can be collected from reception, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time be informing us of your wishes.
If you do nothing we will assume that you are happy for us to create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them. If you are the parent or guardian of a child under 16 then you may request to opt them out and we will consider this request. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand then you should make this information available to them.
I have read and understood

Signed …… Date ……

SHARING YOUR INFORMATION LOCALLY

I, **…… Date of Birth ……** have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet "Your electronic patient record & the sharing of information"

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out (Please circle)

I would / would-not like the information recorded at **RICHMOND MEDICAL CENTRE** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in

I would / would-not like the information recorded at other care teams who are involved in my care to be seen by members of the team at **RICHMOND MEDICAL CENTRE**, where I have granted those care teams the right to add to my shared data.

I understand that I can change my decision at any time.

Patient Signature …….. Date …….

OR

Patient representative …….

Relationship to patient …….