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 and appliances*

**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

NHS Family doctor services registration

GMS1

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

SUPPLEMENTARY QUESTIONS

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:	
 *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.*	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

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.

Bourne Galletly Practice Team
Dr Ian Pace Dr Antony Wright Dr Paul Cregor
Mr Ian Robinson Dr Rebecca Mitchell
The Surgery, 40 North Road, Bourne, Lincolnshire PE10 9BT
Phone: 01778 562200 Fax: 01778 562207

Audit – C

Patient Name: **D.O.B**:

Address:

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per months	2 – 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if a female, or 8 or more units if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Part 1 Score…….

Scoring – A total of 5+ indicates increasing or higher risk of drinking. An overall total score of 5 or above is AUDIT-C positive.

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you 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 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 in the last year		Yes, during the last year	

Part 2 Score …….

Total Score…….

Bloods: Date _____ Time: _____

NPHC: Date _____ Time _____

With _____ EMIS # _____

Please complete in BLOCK CAPITALS and tick as appropriate

***HAVE YOU EVER BEEN REGISTERED WITH THIS PRACTICE PREVIOUSLY? YES ☐ NO ☐ *IMPORTANT** **Address previously registered under:**

How do you prefer to be called?	
Home Telephone: **Work Telephone:**	**Mobile Telephone:** **E-mail Address:**
State your Next of Kin: **What relationship do they have to you?** **Their contact Number:**	
Caring for someone: Do you look after someone? ☐ If so, who?	
Cared for: Does someone look after you? ☐ If so who?:	

Please select your Ethnic origin				**British/Mixed British**	
Other Asian		**Irish**		**Chinese**	
Other White		**White & Black Caribbean**		**African**	
White & Black African		**White & Asian**		**Other Black**	
Other Mixed		**Indian/British Indian**		**Caribbean**	
Pakistan/British Pakistani		**Bangladeshi/British Bangladeshi**		**I don't wish to say**	

ARE YOU A UK MILITARY VETERAN? Yes ☐ No ☐ (If yes - Code: 13Ji.)

If yes: state which service: Years served: Service Number:
(Staff use only - Code: 13Ji.)

Please state Your Main Spoken Language (13I):

Prefer not to say (Language not given (13ZG): ☐

Smoking status:

Smoker (137R) ☐ **Number smoked…… Ex-Smoker (137S)** ☐ **Never Smoked (1371)** ☐

Prescriptions and Electronic Prescription Service

If you live more than a mile (as the crow flies) from the Practice you can be a dispensing patient. We will register you for this service unless you nominate a pharmacy below. Note that if you nominate a pharmacy we can never dispense to you again.

If not dispensing do you have a preference of pharmacy where you would like to collect your prescriptions? Please nominate pharmacy _____

May we send the prescriptions electronically (faster and safer)? Yes: ☐ No: ☐

Can we communicate with you via Text messages and email? *

☐ I AGREE to receive communication via text message from the practice (**9NdP**)

☐ I AGREE to receive communication via e-mail from the practice (**9NdS**)

Or

☐ I DO NOT AGREE to receive communication via text message from the practice (**9NdQ**)

☐ I DO NOT AGREE to receive communication via e-mail from the practice (**9Ndy**)

By consenting to receive text messages and e-mails, you agree to let us know if you change your mobile number or e-mail address.

Please note that you can opt-out of text messaging or e-mail at any time by informing the practice.

Name: _____ NHS Number (if known): _____

Signed: _____ Today's Date: _____

It can take several months for your medical records to be received from your previous doctor. We therefore ask all new patients to book an appointment for a New Patient Health Check with our Practice Nurse. Please give the completed form back to the Receptionist who will make an appointment for you.

Summary Care Record patient consent form **

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record (only choose one option)

☐ Express consent for medication, allergies, adverse reactions and additional information (Enhanced Summary care record) **or**

☐ Express consent to share medication, allergies and adverse reactions *only*

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ……

Date of birth: …… Patient's postcode: ……

Surgery name: …… Surgery location (Town): ……

NHS number (if known): ……

Signature: …… Date: ……

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

Name: ……

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk /summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	**Read 2**	**CTV3**
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6

**Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

***GDPR Permissions**

Bourne Galletly Practice would like to contact you by text message and/or e-mail. Text messages and e-mails are an efficient way to communicate with patients. If you agree to receive text message and e-mails from the practice, this will include:

- Appointment booking confirmation (text message)
- Appointment booking reminders the day before your appointment (text message)
- Notification of missed appointments (text message)
- Requests for you to contact the surgery
- Notification when test results are back, and if we need to speak to you
- Reminders to book an appointment (e.g. For a immunisations, annual check-ups, blood tests)
- Invitation to appointments you are eligible for (e.g. NHS health checks, cervical screening)
- Health campaign information
- Surgery information / updates (e.g. Change in opening hours, new service starting etc)
- Information about the status of a referral to hospital or specialist service
- Information about your medication and prescriptions

Information about other services (e.g. contact details)

Application form for online access to the practice online services

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 medical record	☐

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

1. I have read and understood the information provided on the practice website	☐
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐
Signature	Date
For practice use only	

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Method used	Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Documentary evidence provided		
Authorised by		Date
Date account created		
Date login credentials emailled/given		
Level of record access enabled Detailed coded record ☐ All prospective ☐ All retrospective ☐		Notes / explanation
Date clinical assurance completed		Assured by (initials)
Reason for refusal if record access is refused after clinical assurance.		