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

042017_003 Product Code: **GMS1**

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

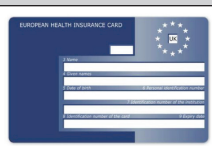
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:
	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.

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Cambridge
CB2 1LR
Tel: 01223 697600
Fax: 01223 697601
Email: capccg.woodlands@nhs.net
Website: www.woodlandssurgery.co.uk
Twitter: @WoodlandsSurg

Dear Patient

Re: New Patient Pack

Welcome to Woodlands Surgery at Eden House. Our aim is to provide a health and wellbeing centre for you. To enable us to do this, this pack contains a leaflet about the surgery as well as the following paperwork and forms we require you to complete:

GMS1 Form
New Patient Questionnaire (overleaf)
Consent Form
Summary Care Record

We do ask you to take time to complete the Questionnaire and return it to the surgery. This information helps us to get to know you. Included are some questions about lifestyle, such as alcohol and smoking status. It is practice policy to advise patients that smoking is harmful to your health and we do run stop smoking clinics to help support you if you wish to quit.

We advise patients with on-going medical conditions especially those on regular medications to make an appointment with one of our Doctors. This will mean that your medications are available on a repeat basis. For those patients on oral contraceptives, please make an appointment with one of our Nurses.

If you need advice for a medical condition whilst the surgery is closed, please contact NHS 111. This is available 24 hours a day, 7 days a week, 365 days a year. Calls are answered by a team of fully trained call advisers who will direct you to the most appropriate and available local service or arrange for an out-of-hours Doctor to call you back or visit.

We hope that you will be very happy with the service we provide and please don't hesitate to contact Kallie Walker, our Assistant Practice Manager if you have any queries.

LARGE VERSIONS OF THIS LETTER AND QUESTIONNAIRE ARE AVAILABLE ON REQUEST.

Yours sincerely

Woodlands Surgery Partners

Please see overleaf for New Patient Questionnaire….

New Patient Questionnaire

*Welcome to Woodlands. Please help us by completing the following, one form for each person who is registering. Please use **BLOCK CAPITALS** for all parts of the questionnaire.*

Title: Mr / Mrs / Miss / Ms / Other	Surname:
Forenames:	Date of Birth:
Other Surname (e.g. maiden name)	Place of Birth **(Required):**
Mobile Telephone Number **(Required):**	Alternative Telephone Number **(Required):**
Languages spoken:	Present Occupation or not working
Are you a student? If so, where:	
E-mail: **(IN CAPITALS PLEASE)**	

White	**Mixed**	**Asian/Asian British**	**Black/Black British**	**Chinese/Other Ethnic Group**
British Irish Other-White Please specify ……..	White/Asian White/Black African White/Black Caribbean	Bangladeshi Indian Pakistani Other-Asian	Black African Black Caribbean Other-Black	Chinese Japanese Other Ethic Group Please specify ……..

First Language:

I am happy to be contacted by the surgery on the details stated above. Including via e-mail or text message to inform me of non-urgent information.

Signed: ……..

If not signed by patient please state your relationship to patient:

…….

OFFICE USE ONLY: Whe coding NPQ – Please tick top two GP detail boxes.

1. **Are you a Carer?**

Please help us identify carers. If you answer YES to any or both of the questions below, please see Reception for a carers pack with more information about how we can help you.

Do you look after someone? **YES/NO**

Does someone look after you? **YES/NO**

2. Your Lifestyle – Please Circle Correct Answers

1. Have you ever smoked? **Yes** – Please continue to question 2 below
No – Please continue to "3. Alcohol" question below

2. Do you still smoke? **Yes** – how many cigarettes or tobacco do you smoke a day? ……..
No - how long ago did you give up? …….

3. Do you use electronic cigarette? **Yes/No**

There are many ways we can help you to stop smoking. Please make an appointment with one of the Practice Nurses or HCA if you wish to receive advice and support on giving up.

3. Alcohol

Do you drink ANY alcohol? **YES** – Please answer the following questionnaire **NO** - Continue onto question 4

How often do you have a drink containing alcohol?	**How many units of alcohol do you drink on a typical day when you are drinking?**	**How often have you had 6 or more units if you are female, or 8 or more units if male, on a single occasion in the last year?**
Never	1 or 2 drinks	Never
Monthly or less	3 or 4 drinks	Less than monthly
2-4 times a month	5 or 6 drinks	Monthly
2-3 times a week	7 or 8 drinks	Weekly
4 or more times a week	10 or more drinks	Daily or almost daily
How often in the last year have you found you were not able to stop drinking once started?	**How often in the last year have you failed to do what was normally expected because of drinking?**	**How often in the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?**
Never	Never	Never
Less than monthly	Less than monthly	Less than monthly
Monthly	Monthly	Monthly
Daily or almost daily	Weekly	Weekly
	Daily or almost daily	Daily or almost daily

How often in the last year have you had a feeling of guilt or remorse after drinking?	How often in the last year have you been unable to remember what happened the night before because of drinking?	Have you or someone else been injured as a result of your drinking?
Never Less than monthly Monthly Weekly Daily or almost daily	Never Less than monthly Monthly Weekly Daily or almost daily	No, Never Yes, but not in the last year Yes, during the last year

Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested you cut down?
No, Never Yes, but not in the last year Yes, during the last year

4. Please tell us your height and weight if you know them.	Height: Weight:

5. How would you describe your diet? (please circle)	Good	Average	Poor

6. Family History

Have you or any of your immediate family (father/mother/siblings/children) suffered from any of the following:

	Please circle	Who in your family?	What type?
Asthma	Yes / No		
Cancer	Yes / No		
Diabetes	Yes / No		
Depression	Yes / No		
Epilepsy	Yes / No		
High Blood Pressure	Yes / No		
Heart Disease under 60	Yes / No		
Thrombosis	Yes / No		

7. Medication

Please write below the medicines, creams, inhalers, pills that you normally obtain by prescription. Please be as accurate as possible.

Name	Dose	Name	Dose

Are you allergic to any medicines i.e. have had a rash or swelling up? Yes/No

Name of medication……

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.

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

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

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

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: _____ Date of Birth: _____

Address:

_____

I hereby consent to the disclosure of my private medical information to:

Name: _____ Date of Birth: _____

Relationship: _____ Tel No:_____

Address:

_____

Please tick the statement/s applicable:

☐ *Full and open ended disclosure of any matter related to my medical record*

☐ *Full disclosure of any matter related to my medical record for the period*

(From) _____ *(To)* _____

☐ *Limited disclosure of the following aspects of my medical record:*

- ☐ *Test Results*
- ☐ *Appointment queries*
- ☐ *Prescription queries*
- ☐ *Referral queries*
- ☐ *Any other matter related to my medical record, please state:*

_____

I am aware that this consent may be revoked by me at any time, in writing to the Practice Manager.

Signature: _____Date: _____

Witnessed by (not the individual for whom consent is being granted):

Signature: _____Date: _____

Address:

_____

_____

If you need assistance in completing this form please contact the Practice Manager.