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*

☐ 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

** Not all doctors are authorised to dispense medicines*

☐ **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 con irming 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 con irming 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**

NHS Family doctor services registration

GMS1

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.

REGISTERING WITH THIS PRACTICE

Dear New Patient,

Thank you for your enquiry about joining the practice; we have pleasure in attaching a New Patient Registration Pack.

NOTE: This practice DOES NOT prescribe Temazepam, Diazepam or Dihydrocodeine unless there is a documented medical need for it.

If you have previously been removed from our registered list of patients due to violent or unacceptable conduct or for continued non-attendance at pre-booked appointments it is unlikely you will be accepted back on to our list. If you wish to discuss this then please ask to speak to the Practice Manager.

Prior to submitting your application to register please contact your current registered practice and ensure that you have provided expressed consent to allow your medical records to be 'shared' with other healthcare organisations, as until we are able to access ALL of your healthcare records we would not be in a position to provide you with safe medical care as we would not have a full medical history to refer to. Your application to register WILL NOT be processed unless we have full access.

Please also check to ensure your permanent address of residency is within our practice registration area as we DO NOT accept registrations outside of the area as stated:

- **Barton Seagrave**
- **Cranford**
- **Geddington**
- **Grafton Underwood**
- **Kettering**
- **Newton**
- **Thorpe Malsor**
- **Warkton**
- **Weekley**

All surgeries are run on an appointment basis; if you cannot attend please cancel your appointment otherwise you will be at risk of removal from our practice list.

All Urgent on the day appointments will be with one of our Advanced Nurse Practitioners.

To complete the registration process we need each person to complete a GMS 1 Registration Form and a Questionnaire. Please also bring your Medical Card if you have it.

Please ensure you complete the forms as fully as possible noting that all applicants must provide the following evidence of identification, and residency at their current address:

Proof of Identity:

- Passport
- Driving Licence [must be photo id style]
- Birth Certificate

Proof of Address: This needs to dated within the last 3 months

- Utility Bill [mobile telephone bills will not be accepted]
- Council Tax Statement
- Bank Statement [no online]
- Other: please state what you are providing

If you have come to this country form abroad and are requesting to register with a doctor it is also necessary for you to provide us with photocopies of your paperwork confirming your entitlement to remain in this country for more than 6 months (original documents must also be available for us to view) documents can be photocopied by the practice for a small charge.

Examples of suitable documents are:

- A current British or European Community Passport
- A work Permit
- A valid visa (with more than 6 months left to run)
- Home Office paperwork for asylum seekers or refugees
- If you are a student, a letter from your college/university confirming the duration of your studies.

Yours sincerely,

Dawn Savage
Practice Manager

DRYLAND SURGERY

New Patient Registration Form

Full Name:	Mobile Number:
Mr Mrs / Miss / Ms / Other……..	Home Phone:
Address and Postcode:	Date of Birth:
	Next of kin:
	Next of kin emergency contact Number:
	How is your next of kin related to you?:
Email address:	

Marital Status:		Gender	Male	NHS Number (if known)

Previous Doctor Name & Address:			Previous Doctor Telephone No:
Are you a British forces veteran? *(a veteran is someone who has served in the forces for at least 1 day)*	Yes	No	If Yes, please provide date you retired: Please provide your Service or Personnel Number:

Your Ethnic Origin: (select one)	White (Uk)	White (Irish)	White (Other)
Caribbean	African	Asian	Other Mixed Background
Indian / British Indian	Pakistani / British Pakistani	Bangladeshi / British Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other	Not Stated

Your main or 1st	English	Hindi	Gujurati	Bengali	Punjabi

language Spoken / Understood (select one)					
Polish	Ukrainian	French	German	Other: (Please Specify)	

Your Religion:	C of E	Catholic	Other Christian	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	Other Religion (state)	

HEALTH AND LIFESTYLE

Physical Details:	Height:	Weight:

Smoking

Are you currently a smoker?	Yes	No	Have you ever been a smoker?	No
If **Yes**, how many cigarettes / cigars / ozs of tobacco do you smoke in a week?			*If you are a smoker and want to stop, please contact the local smoking cessation services First for Wellbeing on Telephone Number 0300 126 5000*	

Alcohol – How much do you drink? (AUDIT C)

Question	0	1	2	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Daily or almost daily	

Scoring: A total of 5+ indicates possible harmful or hazardous drinking

If you require advice regarding your alcohol consumption – please ask at reception

Allergies: Do you have any allergies or have you had an adverse reaction?	Yes *(please provide details to what and the reaction):*	No

Exercise: How often do you exercise?	No. times per week	Type(s) of exercise	None	Moderate	Heavy

Improving access to the practice in relation to disability or sensory loss is important to us.

Is your access restricted? Yes / No

If **Yes**, what is the best form of communication for you? *(please tick or state below)*

Induction Loop	BSL interpreter	Disabled access	Limited mobility	Guide dog access	Interpreter (language)
Alternative format for information	Sight impaired	Hearing impairment	Difficulty with Speech	Other (please specify):	

YOUR MEDICAL HISTORY

Do you currently suffer from any medical problems / conditions / illnesses / disease? Please give brief details and approximate date.	Date	
Have you had any significant medical problems / diseases / illnesses / operations in the past? Please give brief details and approximate date.	Date	

YOUR MEDICATION

Please list any tables, medicines or other treatments you are currently taking: ***You can attach copy of your previous surgery's repeat medication list if you prefer.***	Name of Medication	Dose	How often do you take it?
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)	
Name of Nominated Pharmacy for Electronic Prescribing:			

WOMEN ONLY:	
When was your last smear done?	Date:
What was the result of the smear?	Result:
Date of last mammogram (if applicable)	Date:
Method of current contraception (if applicable)	

YOUR FAMILY MEDICAL HISTORY			
Family History Please tick any of the following that affect your Parents, Brothers or Sisters *(tick all that apply and who it relates to)*	Diabetes	Heart Attack (age 60 or above) Heart Attack (under age 60)	Cancer: (include type)
	Stroke	Asthma	High Blood Pressure

OTHER IMPORTANT INFORMATION		
Are you Cared For? If so please state their name, address, phone no and sign here if you are happy for us to disclose information about your health to your Carer.	**<u>Carer Contact Details</u>** Signed: Date:	
Are you a Carer? If so, please state the name, address and phone number of the person you Carer for:	**<u>Person Cared For Contact Details</u>**	
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If "Yes", please state their name / address / phone number:

ONLINE & TELEPHONE COMMUNICATION SERVICES
(for patients over the age of 13 only)

E-mail :	We only send out general information by email, never confidential information. We will email you our newsletter to keep you up to date on what's happening at the practice and may occasionally e-mail you to ask if you would provide feedback to help us to improve services. If you **ARE HAPPY** for us to contact you by email please tick here (you can opt out / in easily in the future).
Text Messaging [SMS]:	The surgery uses SMS text messaging services to provide both confirmation of appointment booking and appointment reminders. If you **ARE HAPPY** for us to contact you in this way please tick here (you can opt out / in easily in the future).
Online Services:	If you would like to book and cancel appointments, request your repeat prescriptions and be able to view a summary of your medical records on-line then please tick here *N.B. please allow one week after submitting your registration documents, for security purposes you will then be required to come to the surgery with your identification documents to enable the receptionist to provide you with a username and password for this service.*

Named Accountable GP

The 2015-2016 GP contract in England extends the requirement to provide a named accountable GP to all patients, rather than just those over 75. The role of the named GP is to take responsibility for the co-ordination of all appropriate services and ensure they are delivered where required (based on the named GP's clinical judgement) to each of their patients.

Every new patient registering with the practice will be advised of who their Named Accountable GP is and we will continue to encourage all our patients to see that GP wherever possible

SHARING YOUR RECORDS WITH OTHERS

The NHS would like to share your data with other in a number of ways [for further information please ask at reception to see our Privacy Statements].
Please answer the questions below so that we know how you wish us to share your data.

NHS Summary Care Records.

This allows us to share some of your medical information such as your medications, drug sensitivities, and allergies with emergency care services. You do have the right to opt out of this, but we do urge you to allow the sharing of this vital information when needed in times of emergency treatment. This is UK wide. For further information please visit www.nhscarerecords.nhs.uk or telephone the Summary Care Records Information Line on 0300 303 5678. If you do nothing, we will create a Summary Care Record for you. If you would like to opt out please download the form from the website above and, complete and hand in with your registration forms. If you choose not to have a Summary Care Record you can change your mind at any time by informing your GP Practice.

SystemOne Electronic Patient Record

We are one of many clinical facilities that use a secure computerised medical record system called SystemOne. Each facility's records are separate, but because we use the same system, we have the ability to share your information with other care team on the same system in order to improve your care. These include services such as GP Out of Hours Services. But it is your choice whether we share your record with them, and if we can see their records. As your GP surgery, it's vital we keep as complete a medical record for you as we can so we can treat you with full knowledge of all your medical information. You will be asked when you attend another SystemOne facility if you are willing to allow that facility to share their record with us:
Please be assured that your record would only be accessed when the need arouse to support you appropriately and that all staff abide by the NHS rules and security regarding confidentiality:

Sharing Out:	**Yes:** *I would like to share my medical record with other SystemOne healthcare professionals*	**No:** *I would not like to share my medical record with other SystemOne healthcare professionals*
Sharing In:	**Yes:** *I would like Dryland Surgery to see my medical record from other SystemOne units.*	**No:** *I would not like Dryland Surgery to see my medical record from other SystemOne units.*

National Data Opt-out Programme

Information about your health and care helps the NHS to improve individual care, speed up diagnosis, plan local services and research new treatments.
As of the 25th May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patients information safe and always being clear about how it is used.

Please visit www.nhs.uk/your-nhs-data-matters or call 0300 303 5678 to find out more. You can **choose** whether your confidential patient information is used for research and planning

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 our services better.
By expressing an interest, you will be helping us to plan ways of involving patients that suits you.
It will also mean we can keep you informed of opportunities to give your views and update you with developments within the Practice.

If you are interested in getting involved, please tick the box below and we will arrange for a Practice Patient Participation Group Application Form to be sent to you:

I am interested in becoming involved in the Practice Patient Participation Group (please tick the "Yes" box):	Yes

DECLARATION:

I declare that I am / my child* is entitled to NHS service because I have been or intend to be ordinarily resident in the UK for a period of 6 months or longer and I wish to register with Dryland Surgery.

Signature: Date:

If signing on behalf of someone please state your name and relationship to the patient:

DRYLAND SURGERY

NEW FAMILY QUESTIONNAIRE

One Questionnaire to be completed by Parent / Guardian of any Child under 18 Years Old

Welcome to Dryland Surgery.

We are working to improve the care and safeguarding of all children and in order to do this we need to ask all new families registering with us some questions.

Please complete the following questions and return them with your registration forms.

Do you have any children under 18 living with you? (Please circle)

Yes No

If yes please give ages,

……

……

……

Have any children living with you ever been Looked after or fostered?

Yes No

Had a social worker or any support?

Yes No

Had any safeguarding or child protection issues

Yes No

Name of person completing this form: _____

Date: _____

Signature: _____