NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

First names .....

Date of Birth

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 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*

☐ 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

* Not all doctors are authorised to dispense medicines

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

.....

Version 01/02

Please see right re: Organ donation

NHS GSM1

NHS Organ Donation registration

I would like to join the NHS Organ Donation Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate.

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

.....

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give 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: .....

To be completed by your 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

.....

☐ 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.

Authorise Signature

Name Date

Practice Stamp

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

New Patient Questionnaire, Westbank Practice

For office use only
New pt appt reqd with Nurse or Dr: Yes/No
Letter sent:

Please complete ALL pages

Your details	
Full Name:	DOB:
Marital Status:	Married / Widowed / Single
Telephone Numbers	Home:
*Mobile:	Work:
Which is your preferred contact phone number? Home: ☐ Work: ☐ Mobile: ☐	e-mail address:

***If you provide us with a mobile number we will use text as appropriate to contact you unless you tell us otherwise**

Your Next of Kin	
Name:	Phone number & address
Relationship to you:	

If you have children, please provide their name(s) and date(s) of birth

Are you a Carer?	Yes/No If yes who for?	Do you have a Carer?	Yes/No
Present occupation			

Family medical history			
Relatives	Significant illnesses	Or	If deceased, age & cause of death
Father			
Mother			
Sisters			
Brothers			

Past medical history, please tick if you have ever suffered from:					
Asthma	☐	Diabetes	☐	High Blood pressure	☐
Mental illness	☐	Angina	☐	Heart Attack	☐
Stroke	☐	Epilepsy	☐	Thyroid disease	☐
Cancer	☐				

List previous illnesses and operations including dates. Indicate any from which you still suffer or receive treatment

Smoking			
Do you currently or have you ever smoked?	Yes - current smoker ☐	No - never smoked ☐	Ex-smoker ☐ date stopped: _____
If current smoker, amount per day	Cigs_____	Cigars_____	Pipe_____

Alcohol Consumption

(As a rough guide, 2 units of alcohol = a pint of beer OR a medium glass of wine OR a double shot of spirits)

Questions	Scoring System					Enter your score below
	Score					
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	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	7 – 8	10+	
How often to you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Do you take regular exercise?	Yes/No	How often per week? ☐ Once ☐ Twice ☐ Thrice ☐ More
Your height:		Your weight:

Women Only			
If you use any form of contraception please indicate which one:			
Coil ☐	Implant ☐	Oral Pill ☐	Other:
Number of Pregnancies:	Date of last cervical smear:	Date of last mammogram:	Have you ever had a blood transfusion? Yes/No

Immunisations – please indicate those which you have had							
Childhood:							
Tetanus ☐	MMR ☐	Hib ☐	TB/BCG ☐	Polio ☐	Whooping cough ☐	Diphtheria ☐	Pneumococcal ☐
Adult:							
Tetanus ☐	Pneumococcal ☐	Other - e.g. Hepatitis A, B, Rabies etc.					

Do you have any allergies?	Yes/No	If yes please provide details:
Do you have any special needs that will require assistance at the surgery?	Yes/No	If you have any particular communication needs please complete the attached form.

Medication – please list CURRENT medication

Forwarding Prescriptions Please select from the list below where you would like us to send your prescription
☐ **Starcross Boots**
☐ **Exminster Pharmacy**
☐ **Dawlish Warren Pharmacy**
☐ **Boots in Dawlish**
☐ **Collect from the Surgery**
If no preference given, prescriptions will be held at the surgery for collection. Please allow 3 working days for us to send prescriptions to a pharmacy

ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

Name ..... **Date of Birth** .....

A White

	British
	Irish
	Any other white background please write in below:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please write below:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below:

D Black or Black British

	Caribbean
	African
	Any other Black background please write below:

E Chinese or other ethnic group

	Chinese
	Any other background please write below:

F I decline to give this information ☐

Please identify your First Language spoken:

☐ English ☐ French ☐ Spanish ☐ Italian ☐ German ☐ Dutch ☐ Polish

☐ Other – please state ……

SHARING YOUR NHS PATIENT DATA

Information sharing in the NHS is subject to rigorous regulation and governance to ensure your full identifiable and personal medical data is kept confidential and only ever seen by carefully vetted doctors, nurses and administrative staff responsible for overseeing your care.
With the development of information technology the NHS will increasingly be sharing key information from your GP medical notes with Out of Hours GP Services, Hospital A&E Units, Community Hospitals, Community Nurses all of whom may at various times in your life be looking after you. Sharing information can improve both the quality and safety of care you receive and in some cases can be vital in making life-saving decisions about your treatment.

There are two different elements aimed at ensuring continuity and safety in your personal care:

- **SCR = The NHS Summary Care Record**
- **EDSM = The Enhanced Data Sharing Model 'SystmOne'**

We ask you please to read the information on this page carefully and complete the relevant fields on the form overleaf, sign and return to us.

SCR = NHS SUMMARY CARE RECORD

The NHS Summary Care Record was introduced many years ago to help deliver better and safer care; it contains basic information about:

- Any allergies you may have
- Unexpected reactions to medications, and
- Any prescriptions you have recently received.

The intention of the SCR is to help clinicians in Hospital A&E Departments and GP 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians are only allowed to access your SCR record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Patients under 16 years have an NHS Summary Care Record created for them so if you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.

EDSM = ENHANCED DATA SHARING MODEL – SYSTMONE

The Westbank Practice uses a computer system called SystmOne that gives your GP the facility to share your full electronic records across different NHS Care Services that are involved in your care. Allowing your GP to share your record in the 'SystmOne' database helps to deliver better and safer care for you. You can choose to share or not to share your electronic GP record with other NHS Care Services. If you chose to decline sharing you are able to determine if data is 'shared out' and/or 'shared in'

Sharing OUT controls whether information recorded at our GP practice can be shared with other NHS health care providers.

Sharing IN determines whether or not our GP practice can view information in your record that has been entered by other NHS services who are providing care for you or who may provide care for you in the future (*that you have consented to share out*).

Please complete and sign the form overleaf to detail your personal decisions regarding NHS patient data sharing.

NHS PATIENT INFORMATION SHARING – MY CHOICES

Please complete and/or tick the grey boxes below to detail your personal decisions:

It is very important you sign this form to say that you understand and accept the risks to your personal health care if you do decide to opt out of SCR or EDSM. Hand the completed form in to your GP Surgery; they will scan this form into your NHS GP Medical Records and enter the appropriate computer codes.

Patients full NAME	
Patients DATE OF BIRTH	

1. SCR - NHS SUMMARY CARE RECORD

Please tick only one box.

- ☐ Express consent for medication, allergies and adverse reactions only
- ☐ Express consent for medication, allergies, adverse reactions and additional information
- ☐ Express dissent – Patient does not want a summary care record and fully understands the risks involved with this decision

If you do not return this form, a Summary Care Record will be created for you based on implied consent.

2. EDSM – ENHANCED DATA SHARING MODEL - SystmOne

Sharing Out – Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that may care for you?

- ☐ YES share data with other NHS organisations
- ☐ NO do NOT share any data recorded by my GP Practice; I fully accept the risks associated with this decision

Sharing In – Do you consent to your GP Practice viewing data that is recorded at other NHS organisations and care services that may care for you?

- ☐ Consent Given
- ☐ Consent Refused; I fully accept the risks associated with this decision.

Patient's SIGNATURE		**DATE**	

If you are filling out this form on behalf of another person or a child please ensure you fill out their details above and your details here:

Your Name		Your signature	
Relationship to Patient		Date	

WESTBANK PRACTICE

PATIENT CARE SMS TEXT MESSAGING SERVICE
CONSENT FORM (16 years + only)

SMS Messaging Service – Would you like to receive text message appointment reminders and other notices from the Westbank Practice?	Yes ☐ No ☐	If yes, sign consent below

Text messages are generated using a secure facility. However, text messages are transmitted over a public network onto a personal telephone and as such may not be secure. The practice will not transmit any information which would enable an individual patient to be identified. It is your responsibility to maintain the safety of your mobile to avoid anyone else being able to access a SMS text sent to you.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

You are responsible for informing the Surgery of your correct mobile telephone number and you need to notify the Surgery should this number change. The Westbank Practice cannot be held responsible for messages sent to this number in case you fail to inform us of any relevant changes.

I consent to the practice contacting me by text message for the purpose of health promotion and for appointment reminders. I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Mobile No			
Name (print)		Date of Birth	
Signature		Date	

Please complete form overleaf for Children

WESTBANK PRACTICE

PATIENT CARE SMS TEXT MESSAGING SERVICE
Parental Consent for patients up to 13 years of age

SMS Messaging Service – Would you like to receive text message appointment reminders and other notices from the Westbank Practice?	Yes ☐ No ☐	If yes, sign consent below

Text messages are generated using a secure facility. However, text messages are transmitted over a public network onto a personal telephone and as such may not be secure. The practice will not transmit any information which would enable an individual patient to be identified. It is your responsibility to maintain the safety of your mobile to avoid anyone else being able to access a SMS text sent to you.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

You are responsible for informing the Surgery of your correct mobile telephone number and you need to notify the Surgery should this number change. The Westbank Practice cannot be held responsible for messages sent to this number in case you fail to inform us of any relevant changes.

This service is now available for children up to 13 years of age. Parents / Guardians are able to register their children who are under the age of 13 years but once the child reaches their 13th birthday this facility will be removed and the mobile number below deleted from their record. This is to ensure that patient confidentiality is maintained as best as possible and you will receive prior notification from the Practice before this access is removed. The requesting parent/guardian must be registered at the same address as the child in order to access this service.
For now, this service is not available for 13 to 15 year olds, although they will be able to re-register in their own right from their 16th birthday.

I consent to the practice contacting me by text message for the purpose of health promotion and for appointment reminders for my child. I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Mobile No			
Child Name (print)		Date of Birth	
Name (print)		Date of Birth	
Signature		Date	

Westbank Practice

ACCESSIBLE INFORMATION NEEDS QUESTIONNAIRE

We wish to understand and record any particular communication needs you might have. We will then do our best to meet your needs in all contacts with the Practice.

Name ……

Date of birth……

Completed by patient / guardian / carer

Date completed …….

1. **Is your communication with others affected by a health problem or disability which has lasted, or is expected to last, at least 12 months?**

   YES / NO

   If YES please complete the rest of the questionnaire

   If NO you don't need to answer any other questions

2. **What health problem or disability do you have?**

   …….

   …….

3. **What is the best way for us to send you information?**

   ……

   ……

4. **Do you need written information in a format other than standard print?**

   ……

   ……

5. **What communication support could we provide for you at appointments?**

   ……

   ……

6. **Can we share this information with other health and social care providers?**

   YES / NO