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_____/_____/_____

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

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:

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

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

Wistaria and Milford Surgeries

Wistaria Surgery
Wistaria Court
18 Avenue Road
Lymington
Hampshire
SO41 9GJ

Tel 01590 672212
Fax 01590 679930

Partners

Dr Gareth Morris
Dr Angela Sizer
Dr Elizabeth Pugh
Dr Ian Murray
Dr Toni Benning

Practice Manager
Mrs Jan Lamont

Dr Matthew Turner
Dr Alice Mavrogordato
Dr Neil Moody Jones
Dr David Fowler

GP Associates
Dr Camilla Janssen
Dr Victoria Makin
Dr Ben Pettifer

Milford Medical Centre
Sea Road
Milford on Sea
Lymington
Hampshire
SO41 0PG

Tel 01590 643022
Fax 01590 644950

Dear Patient

New Patient Health Check

Welcome to Wistaria and Milford Surgeries. I am inviting you to attend the surgery for a New Patient Health Check.

Please sign and return the attached GMS1 form and new patient questionnaire covering your medical and social circumstances and make an appointment to see our Healthcare Assistant.

Whilst every endeavour will be made to register you with the doctor of your choice, it is not always possible to do so, as their list may be full and therefore closed. We will notify you within a month of application if you have not been accepted.

Yours sincerely

Jan Lamont
Practice Manager
Wistaria & Milford Surgeries

I accept/refuse the invitation for a New Patient Health Check

Signed……..

Print Name……

Date……..

WISTARIA AND MILFORD SURGERIES

CONFIDENTIAL MEDICAL REGISTRATION FORM

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other-please specify

.....

We would be grateful if you would take the time to answer the following questions. The answers are confidential and will go on your medical record helping us to identify your health needs. All new patients are offered a New Patient Medical – **Please ask at Reception.**

When returning this form to the Surgery, we also require you to bring a form of identification to confirm your identity (photo ID) and address (eg. passport, driving licence, bank statement, credit card statement, P60)

☐ ID checked by _____

PLEASE ATTACH A BLOOD PRESSURE READING : You can obtain this by using the blood pressure machine located next to reception

Please complete all pages in FULL using BLOCK capitals

Surname

First names (in full)

Previous surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of birth (day/month/year) NHS Number

Town & country of birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your carer

Are you happy for us to contact your carer about you? ☐ Yes

Please also complete a Carer GP registration form

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Allergies.….

Please list any allergies you have to any drugs/medication

Name of medication	What was the problem or upset?

List of current medication……

If you have a copy of your repeat medications, please pass to Reception

Name of medication	Dosage

Family History ……..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following:

Heart disease under 60	Heart disease over 60	Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Please indicate which family member was affected in each box

Immunisations ……

Immunisation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Lifestyle ……

Height:	Weight:

Smoking ……

Do you smoke: ☐ Yes ☐ No

If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐ Pipe

Are you an ex-smoker? ☐ Yes ☐ No

When did you give up?

How many cigarettes/cigars do you smoke daily?

☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like to help to quit smoking? ☐ Yes ☐ No

Alcohol ……

Do you drink alcohol: ☐ Yes ☐ No If yes, please answer the following questions:

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 ☐ 7-9 ☐ 10+

How often do you have 6 or more standard drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Exercise ……

Do you exercise: ☐ Yes ☐ No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

If yes, when is your baby due?

Do you have any children? ☐ Yes ☐ No

If yes, how many?

Which method of contraception (if any) are you using at present?

Have you had a cervical smear test? ☐ Yes ☐ No

If yes, what was the result? (if known)

Date (if known)

Ethnic Origin……

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.

A White

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

What is your first language? eg. English.

Next of kin ……

Name: Tel number

Relationship DoB

Emergency contact? ☐ Yes ☐ No

Do you give consent for them to discuss your health records? ☐ Yes ☐ No

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐

Patient Information Management

Name: **Date of Birth:**

Data sharing consent choices

To maintain continuity of clinical care, we upload certain medical information so that it is available to other healthcare organisations. You have the right to prevent confidential information about you from being shared or used for any purpose other than providing your care, except in special circumstances.
The law requires doctors to provide some very limited information about certain things. The law says, for example, that doctors must provide information to local authorities about some infectious diseases, eg if you had food poisoning. Very rarely, doctors may be required to disclose information in order to detect a serious crime. Likewise, a court order can require doctors to disclose certain information during a court case.

NHS England aims to link information from all the different places where you receive care, such as hospital, community service and your GP Surgery. This will allow them to compare the care you received in one area against the care you received in another.

Information will be held in a secure environment called the Health and Social Care Information Centre (HSCIC). The role of the HSCIC is to ensure that high quality data is used appropriately to improve patient care. The HSCIC has legal powers to collect and analyse data from all providers of NHS care. They are committed, and legally bound, to the very highest standards of privacy and confidentiality to ensure that your confidential information is protected at all times.
This data can also be used, with permission, for research purposes.
If you do not wish to share data for research, you can opt out:

- You can object to information containing data that identifies you from leaving the Practice. This will prevent identifiable information held in your record from being sent to the HSCIC secure environment. It will also prevent those who have gained special legal approval from using your health information for research.

- You can also object to any information containing data that identifies you from leaving the HSCIC secure environment. This includes information from all places you receive NHS care, such as hospitals. If you object, confidential information will not leave the HSCIC and will not be used, except in very rare circumstances for example in the event of a public health emergency.

For more information
Visit **www.england.nhs.uk/caredata**

Data for Research

I am happy for identifiable data about me to leave the practice ☐

I do not wish identifiable data about me to leave the practice ☐

I am happy for data about me to be shared by HSCIC ☐

I do not wish data about me to be shared by HSCIC ☐

Summary Care Record (SCR)

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. This does not include diagnosis or procedures.
Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.
For more information
Phone 0300 123 3020 or visit **www.nhscarerecords.nhs.uk**

Summary Care Record

I am happy to have a Summary Care Record ☐

I do not wish to have a Summary Care Record ☐

N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.

Hampshire Health Record (HHR) and Your Record on our Clinical System

The HHR is an electronic summary record for people living in Hampshire, Portsmouth and Southampton. GP surgeries, hospitals, social care and community care teams collect information about you and store it electronically on separate computer systems. The Hampshire Health Record store summary information from these organisations in one place so that – with your consent – professionals can view it to deliver better care to you.
This record contains more information than the SCR, but is only available to organisations in Hampshire.
For more information visit **www.hantshealthrecord.nhs.uk**

Hampshire Health Record and Your Record on our Clinical System

I am happy for information about me to be shared between the Practice and other services with access to our clinical system ☐

I do not agree to information about me being shared between the Practice and other services with access to our clinical system ☐

Objecting on behalf of others

If you are a carer and have a ***Lasting Power of Attorney for Health and Welfare*** then you can object on behalf of the patient who lacks capacity. If you do not hold a ***Lasting Power of Attorney*** then you can raise your specific concerns with the patient's GP.
If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

Fit Note Data Extraction & Publication

Practices have received a communication from the Health and Social Care Information Centre (HSCIC) on the extraction & publication of fit note data.

The extraction is intended to allow the Department of Work and Pensions (DWP) to collect data on fit note usage to inform policy development and evaluate the Fit for Work Service. The data being collected will be fully anonymised and will include:

- The number of computer-generated fit notes issued
- The number of patients recorded as 'unfit' or 'maybe fit' for work
- Fit note duration
- Gender
- Health condition type aggregated to high level diagnosis code
- Location, including CCG area
- Whether workplace adaptations were recommended.

HOW CAN WE CONTACT YOU?

Please indicate only if you are **NOT** happy for the surgery to contact you by the following means – otherwise consent will be assumed. You can change consent at any time by contacting the surgery.

No consent for email ☐ This will be to send you letters, newsletters etc.

No consent for text ☐ This will be to send you reminders of appointments

No consent for letters ☐ This will be to invite you for appointments and send you information.

ON-LINE PATIENT ACCESS

Online access enables you to book appointments, request repeat prescriptions and view medication, allergies and immunisations. If you would like to sign up for on-line patient access, please tick the appropriate box below. Online registration information will be posted to your registered address.

☐ **Yes** ☐ **No**

Repeat Prescriptions

These can be requested online – see above.

Paper based requests to the surgery

On the right hand side of your prescription there is a detachable white sheet that is your repeat prescription re-ordering slip.

When you require more medication, please tick it on your slip and return the slip to the surgery via the letterbox at reception or by post or fax. If you wish us to return your prescription to you by post, please enclose a stamped, addressed envelope.

Many of the local pharmacies will arrange collection of your prescriptions from the surgery – contact your local pharmacy for this service.

Nominated Pharmacy

You can nominate your local pharmacy as the automatic destination for medications so that you won't need to come to the surgery to collect your repeat prescription to take to the pharmacy.. Please speak to your pharmacy about this service.

Please allow **48 working hours** for us to issue your prescription.

Telephone and e-mail requests are not accepted as these can be subject to error.

Signature ……

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐