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 confirming 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 confirming 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.

THE HAVEN PRACTICE

Patient Registration Form for Adults

Your Named Accountable GP who is responsible for your care is Dr L Tate

All forms MUST be completed in full before we are able to process your Registration for each person wishing to join the Practice.

Surname:	**Forename:**
Date of Birth:	**Landline:**
Mobile No:	**E-Mail:**
INFORMATION ABOUT YOU Do you have a Carer? Are you a Carer? Are you Registered Disabled? **ILLNESSES:** Have you had any serious illness? Do you have any medical problems at the moment? Please list any allergies you have: Please list any tablets, medicine or other treatments you are taking or bought from a chemist: Are there any serious diseases that affect your family?	
PERSONAL INFORMATION **Next of Kin:** Name: Relationship: Contact Details including address;	

Religion:	

IMMUNISATIONS: Please circle which Immunisations you have been given:	
Diphtheria/Tetanus/Polio	Measles/Mumps/Rubella
Pertussis (Whooping cough)	Meningitis B
HPV (Cervical Cancer)	Meningitis C
Rotavirus	Hepatitis B
Haemophilus(Hib)	Pneumococcal
Men ACYW	Shingles

SMOKING:

Do you smoke?

If 'No', have you ever smoked?

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

Would you like advice on giving up smoking?

Approx. weight and height?	Weight: Height:
Are you on any special diet?	

MEDICAL INFORMATION

Do you suffer from any of the following?

Anxiety	**Depression**
OCD	**Bipolar Disorder**

If yes to any of these, please state the year(s) when were you first diagnosed?

CERVICAL SCREENING

Women only: when was your last smear taken?

Ethnic Group(Please tick)

White	British ☐	Irish ☐	Other		
Black	Caribbean ☐	African ☐	Other		
Asian	Indian ☐	Pakistani ☐	Chinese ☐	Other	
Mixed	White + Black Caribbean ☐ White + Black African ☐ White + Asian ☐ Other ☐				

Alcohol Screening Tool Form

Please complete the Audit below.

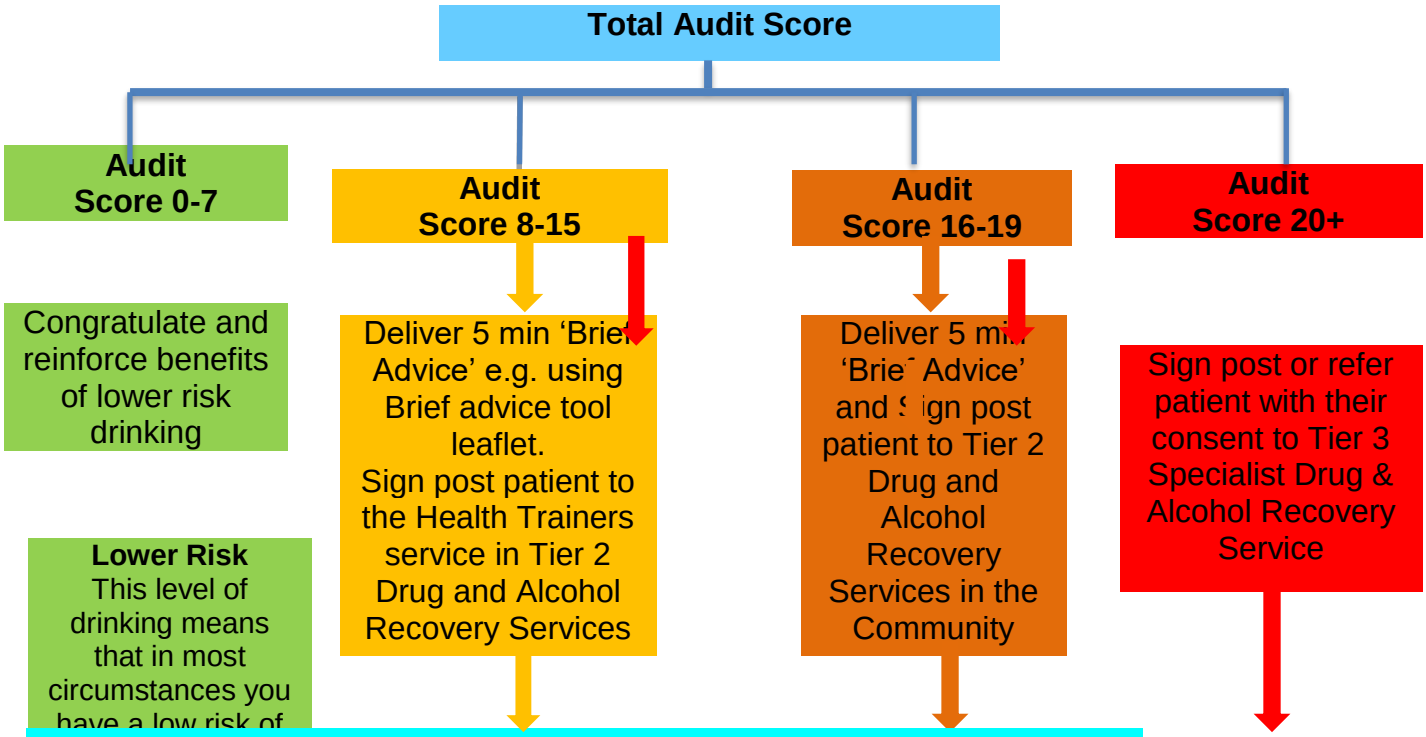
AUDIT – C First 3 Questions	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times per Month	2-3 Times per Week	4+ Times per week	
How many units of alcohol do you drink on a typical day when you are drinking	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female or 8 or more id male on a single occasion in the last year	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Full Audit: Remaining 7 Questions		**Audit C Score Complete Full Audit if Score is Greater than 5**				
How often during the last year have you found that you were not able to stop drinking once you had 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 not 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 not in the last year		Yes, during the last year	
					Score Equals	
TOTAL score Equals =AUDIT C score (above) + score of remaining 7 questions						

Scoring: Add the ten scores together to identify necessary action (e.g. Brief Advice)

Total AUDIT score ☐

"Based on your answers, your drinking places you in the…risk category."
(for 8+ scores lead to Brief Advice with) "How do you feel about that?"

Audit Score	Risk Category	Desired Action
0-7	Lower Risk	❖ No intervention required
8-15	Increasing Risk	❖ Brief advice and sign post to Tier 2
16-19	Higher Risk	❖ Brief advice and sign post to Tier 2
20+	Possible	❖ Referral to Tier 3 services
Dependence		



Lower Risk
This level of drinking means that in most circumstances you have a low risk of

In a situation where the patient does not respond to 'Brief Advice' or wants to discuss alcohol consumption further, and 'Extended Brief intervention' (i.e. 20-30 mins motivational interviewing), should be offered.
Within the community both the Health Trainers & Pavilions have practitioner's trained in Motivational Interviewing who can offer the patient a series of 'extended brief interventions' to help them achieve their desired behaviour & goals in reducing alcohol.

serious medical conditions (AUDIT score 16 – 19)

Higher Risk
This level of drinking has the greatest risk of health problems (AUDIT score 20+)

Pavilions drug & alcohol services can be contact on 0800 014 9819 or via referrals@paviliona.org.uk
They offer a drop in service from 10am-4pm Monday- Friday at 26 Ditchling Road BN1 4SF or at 9 The Drive, Hove, BN3 3JE.
Website: www.pavilions.org.uk

Communications

I consent to the Practice contacting me by:

Email	☐ Yes	☐ No
Text	☐ Yes	☐ No

There are a number of scenarios in which we may use an SMS message or Email:

- ❖ Appointment reminders, changes or cancellations.
- ❖ Flu or other Vaccination clinics for targeted eligible populations
- ❖ Annual Review invitations
- ❖ Cervical Screening
- ❖ Child Immunisation reminders
- ❖ Blood Pressure and Cholesterol monitoring
- ❖ Smoking Status updates
- ❖ Invitations for Patient educational sessions (e.g. diabetic self-help groups)
- ❖ Requests to contact the Practice to arrange appointments
- ❖ Blood Test and Injection due
- ❖ Messages from the GP
- ❖ Updates on changes to the Practice such as clinics
- ❖ Informing Patients of test results or other information relevant to their care (please see further information below Special category data)

Pictures sent to the Practice

Please be aware any digital image submitted as part of an online consultation, will be stored within your clinical notes

Special Category Data

Information such as test results (this includes any results, not just those relating to sexual health tests) or details of medication (ie. information which is specific, sensitive and individual to one person) will only be communicated via SMS messaging with additional consent provided by the patient on those occasions (for example, agreed between patient and GP when arranging a certain investigation during an appointment). This additional consent will be recorded in your medical records at that time.

If you make a request the Reception team for a copy of your results they will be asked to email the Practice written consent for this. The Doctor will need to give them permission for this to be actioned. Your written consent will be scanned onto your record.

Opting Out

We understand that some Patients will not want to receive SMS text messages from us. We ask that patients carefully consider the advantages of receiving these messages before choosing to opt-out. If you do choose to opt out please inform our Receptionists or the Clinician you are seeing.

Electronic Prescribing Service

The Electronic Prescribing Service allows us to send your prescription forms electronically to your nominated, preferred choice of local pharmacy to be made up and collected at your convenience. Please ask reception for a leaflet for further information.

Pharmacy Nomination:	
Pharmacy Post Code:	
Patient Name:	

I am the Patient/Carer of the patient named above. Nomination has been explained to me and I have also been offered a leaflet that explains the nomination process.

Signed_____Dated_____

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 that 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.

a) Express consent for medication, allergies and adverse reactions only. You wish to share information about medication, allergies and adverse reactions only.

b) Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.

c) 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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

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

You have a choice- Having read the above information regarding your choices; please choose **one** of the options below:

Yes – I would like a Summary Care Record

□ **SCRAI** - Express consent for medication, allergies, adverse reactions and additional information.

□ **SCR -** Express consent for medication, allergies and adverse reactions only.

or

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record **(opt out).**

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

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

Name: …….....

Signature: …… Date: ……

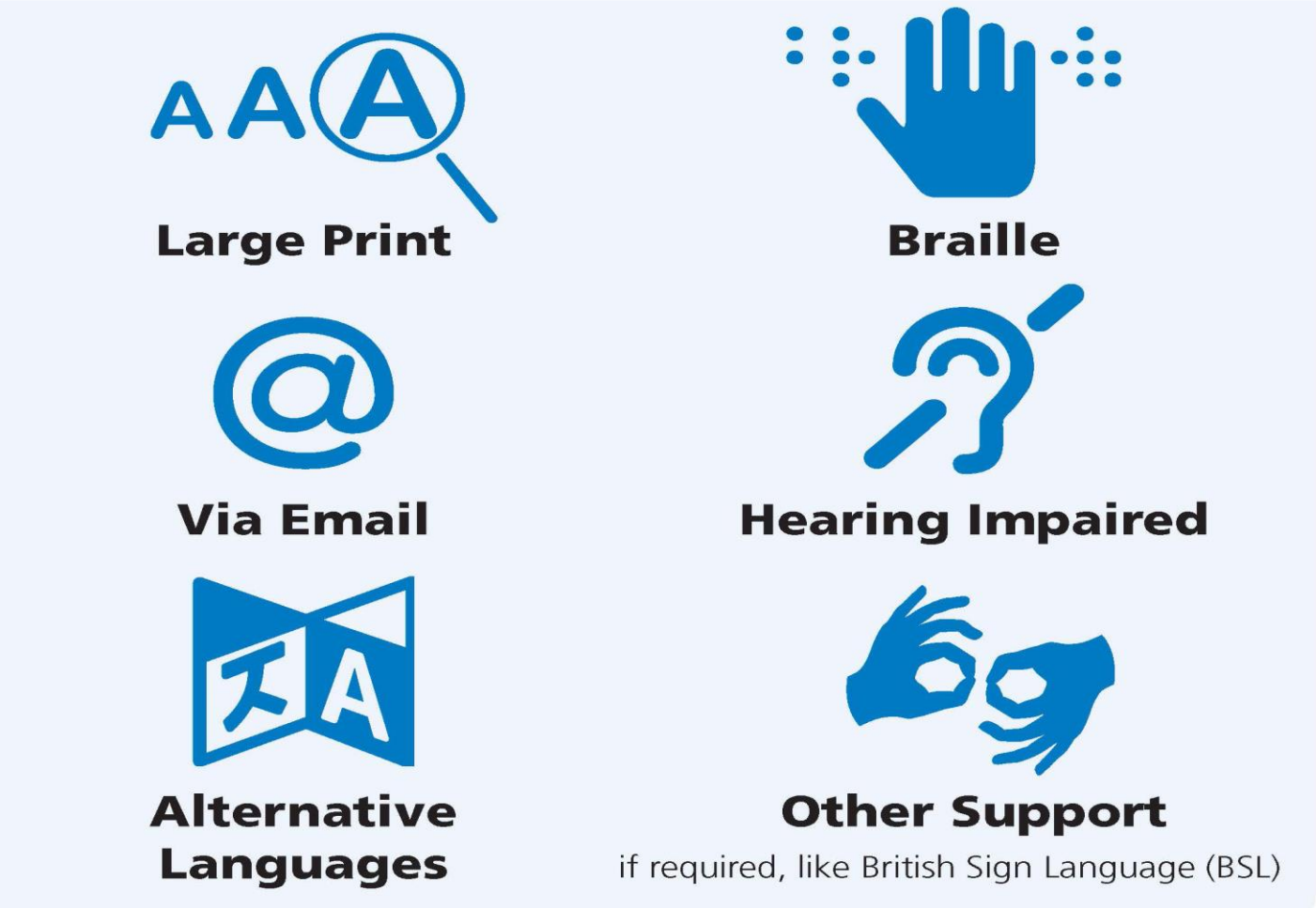
Please circle one:

Patient **Legal Guardian** **Lasting Power of Attorney and Welfare**

Special Information and Communication Needs

Do you have a Disability, Impairment or Sensory Loss and nee to receive information in a way you can easily understand?

Please tick: ✓



Please let us know of any Services you may require:

Patient Online Access
Important Information – Please read before returning this form

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.
Proxy Access: Parents may request a proxy access to their children's records; this will cease automatically when the child reaches the age of 11. Any subsequent proxy access will need to authorise by the patient subject to a competency test being completed.

More information

For more information about keeping your healthcare records safe and secure please visit our website: www.osmp.co.uk

THE HAVEN PRACTICE

Patient Online Registration Form
Access to GP Online Services for Adults

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		**Mobile number**	

I wish to have access to the following online services (tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing Detailed Coded Read Access Excluding Free Text, Letters and Documents	☐

Application for Online Access to My Medical Record

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

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

❖ **I have read and understood the information on the reverse of this form**	☐
❖ **I will be responsible for the security of the information that I see or download**	☐
❖ **If I choose to share my information with anyone else, this is at my own risk**	☐
❖ **I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement**	☐
❖ **If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible**	☐

Signature		**Date**	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date

THE HAVEN PRACTICE

Patient Participation Group Member

We have an active Patient Participation Group at the Practice already established but would like to make the group as representative of our Practice population as possible.

We will let you know when our next group is meeting, this is usually four times a year or quarterly at lunchtime when the Practice is closed.

This group is designed to support developments and bring new ideas to the Practice**.** Members are not committed to attend every meeting so if you would like to be involved you can give as much or as little time to the group as you wish.

If you cannot make it to the surgery we welcome you to take part as a 'virtual member' via email, whereby you will still receive the agendas, minutes and other information in relation to the meetings and other events being held by the group.

We would like to know how we can improve our service to you and how you perceive our surgery and staff.

PPG Member ☐ Yes

Please add me to the list

PPG Member Virtual ☐ Yes

Please send me information via email

You can opt out anytime from this group by contacting us.

January 2021