West Road
MEDICAL CENTRE

Your appointment details ADULT:

Name:

Registration Date:

Registration Time:

With:

It is very important that you arrive on time for registration. We will not be able to register you if you are late.

What you need to bring to your appointment:

1. Completed purple 'GMS1' form
2. Completed new patient questionnaire
3. Any medication you are taking
4. Official photographic ID ☐
5. An original copy of a utility bill dated within the last 3 months ☐
6. Urine sample

If you are unable to attend this new appointment please cancel it in advance. Patients who do not attend will not be offered another appointment.

If you are phoning on a Saturday please call 07532 035077

If you need this form in large print, different format, easy read or via email please let us know at reception and we can sort this out for you.

disability confident EMPLOYER

Dr B Palmer, Dr M Heardman, Dr K Bisset, Dr L Duncan, Dr L Longworth
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West Road
MEDICAL CENTRE

Dear Patient,

Welcome to the West Road Medical Centre. We would like to provide you with a high standard of care whilst you are registered with us.

- Attached you will find a practice booklet and a health status questionnaire. The practice booklet provides you with all the information you need to know about the practice and the services we offer including opening times and the procedure for ordering repeat prescriptions.
- You MUST complete the attached health questionnaire and bring it to your appointment. This information is vital and will provide us with the necessary knowledge to plan your health care appropriately prior to receiving your patient records from your previous practice (if this applies). Please also complete the online access form and we will provide you with online access to prescriptions and appointments.
- In this pack is a urine sample bottle. Please bring this to your appointment.
- If you are currently taking any medication, please bring them with you to your appointment.
- Please inform us if you are living with or moving to an address with someone who is already registered with us.
- Please tell us if you are a carer for somebody or if somebody cares for you.
- You must provide proof of identity such as a passport, driving licence, previous medical card etc. We will be unable to process your registration further until these are provided. If you are homeless and have no proof of address please let us know.
- If you need an **interpreter/translator** please let us know as quickly as possible and we can book this in.
- Please remember this appointment is for you only. If you also wish another member of your family to be registered please contact our Reception Staff.
- The practice is participating in Summary Care Record. If you choose to have a summary care record you do not need to do anything, this will happen automatically. If you choose not to have a summary care record then you need to let us know by filling in an opt-out form which you can collect from reception.
- The practice uses computerised patient records which can be shared with other care organisations for the benefit of your care. A leaflet about this is enclosed – please tell us if you do not consent to this.

The reception team are there to help you if you wish to clarify anything about the service we offer, please ask.

Yours sincerely,

Dr Palmer
Senior Partner

NEW PATIENT QUESTIONNAIRE
Welcome to West Road Medical Centre. You must complete all sections on this form and bring it to your new patient appointment along with the purple GMS1 form or medical card. If this form is not completed in full you will not be able to register at this practice.

Today's date:	**Date of Birth:**
Mr / Mrs / Miss / Ms / Mx / Other:	Male / Female:
Surname (family name):	**First Name:**
Address: Home Telephone Number: Mobile Number (we will use this to send appointments by text):	
Next of kin: Name: Address: Telephone number:	
Are you a carer/do you look after someone? (Name the person and the relationship) **Do you have a carer?** (Name the person and the relationship)	
Please detail any special needs that you have (eg disability, sensory loss or communication needs etc): Do you need any help with communication? Eg large print, easy read, sign language, braille etc…	
Have you, or are you suffering from any of the following? (please circle) If so, you must make an appointment to see the Practice Nurse. Stroke / Heart Attack / Blood pressure / Diabetes / Depression / Cancer / Epilepsy / Asthma / Angina / Thyroid problems / Lung Disease / Dementia	
Are you under the care of any hospital specialist at present? Yes / No **Please detail:**	
Have you had any serious illness, accidents or operations? Yes / No **Please detail:**	
Please detail any **regular** medications you are taking (either on prescription or bought over the counter) Please bring all boxes/bottles/packets of your medication to your appointment Name of medicine / Dose / Strength / How many times a day _____ _____ _____ _____ _____ _____ _____ _____ _____	
Please detail any allergies that you suffer from:	

West Road
MEDICAL CENTRE

Do you smoke? Yes / No / Ex-Smoker / Have never smoked tobacco
If yes, how many cigarettes do you smoke a day?

If ex-smoker, when did you give up?

Do you drink alcohol? Yes / No If you answered yes, please complete the following:

Questions	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 do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost monthly

Which word best describes you level of activity? Inactive / Gentle / Moderate / Vigorous

If a close relative (parent/brother/sister) has had any of the following please let us know which relative and how old they were when it happened:

Stroke: Yes / No Relationship: Age:
Heart Attack: Yes / No Relationship: Age:
Breast Cancer: Yes / No Relationship: Age:
Diabetes: Yes / No Relationship: Age:
Bowel Cancer: Yes / No Relationship: Age:
Asthma/COPD: Yes / No Relationship: Age:

What immunisations have you had?

For women only:
How many pregnancies have you had?
Have you ever had problems in pregnancy? Yes / No
If yes please detail:
Are you currently using birth control? Yes / No
If yes please select: Pill / Injection / Coil / Implant / Other .....
When was your last smear test?

Are you a military veteran? Yes / No

Do you have a probation officer? Yes / No - if Yes please supply name and telephone number (we may contact your probation officer to help us complete a risk assessment)

Do you have a social worker? Yes / No – if Yes please supply name and telephone number

Do you have an advocate? Yes / No - if Yes please supply name and telephone number
I do/do not consent to me electronic record being shared with other organisations in my care (see enclosed leaflet.)

Do you need an interpreter? Yes / No
Which ethnic group do you belong to?
What is you first language?
What is your religion?

Thank you for taking the time to complete this questionnaire.
If you are unable to attend your new patient appointment please let us know as soon as possible.

To be completed at your new patient appointment:

Height:	**Weight:**	**Blood Pressure:**

Electronic Prescriptions

Unless you specify a pharmacy which you would like your prescriptions to be sent electronically to we will automatically put you down for Lloyds Pharmacy next door to the practice. If you have a preferred Pharmacy please write below.

……
……

Patient Forum

Would you like to share and represent the views of patients with fellow patients and the Practice?
Would you like to:

- Attend monthly patient forum meetings?
- Discuss issues and put forward the views of patients?

Tick this box to join our Patient Forum ☐

How Would You Like Us To Contact You?

☐ Telephone ☐ Text (Mobile Number) ……

☐ Email …… ☐ Postal Letter

☐ Other (Please specify)
……

When returning this form you MUST bring photographic ID with you.

Application for online access to book appointments & order repeat prescriptions

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

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

Signature or Patient / Parent or Guardian	Date

If you wish to have access to your medical record online, you can request this via the Online Account Management tab on your account homescreen.

For practice use only

Patient NHS number	Date
Identity verified by (Staff Member)	Method Photo ID ☐
Notes / explanation	

Identification

In order to request access to online services you will need to provide photographic evidence of identification (ID) in the form of:

- **Passport**
- **Driving licence**

If you cannot provide either of the above then a combination of two of the following will be considered as suitable forms of identification:

- Paid utility bills
- Local authority rent card
- Marriage certificate
- Birth certificate
- Papers from the Home Office or UK Borders Agency
- Bank/building society cards/statements

- Payslip / P45 / National Insurance number card
- Letter from Benefits Agency/benefit book/signing on card
- Photographic student card

We will not accept the following documents as proof of identification:
- Library card
- Video/DVD rental card
- Health club card

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

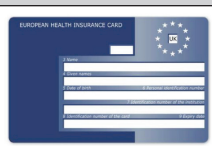
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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.