The Department of Health has requested that we collect Ethnic Data for the planning of health needs throughout the Country. Completion of the following section is optional.

All information provided will be treated as confidential.

| | | | |
|---|---|---|---|
| WHITE | | BLACK OR BLACK BRITISH | |
| British Group | ☐ | Caribbean | ☐ |
| Irish | ☐ | African | ☐ |
| Other | ☐ | | |
| MIXED | | ASIAN OR ASIAN BRITISH | |
| White & Black Caribbean | ☐ | Indian | ☐ |
| White & Black African | ☐ | Pakistani | ☐ |
| White & Asian | | Bangladeshi | |
| CHINESE | | DECLINE | |
| Chinese | ☐ | Declined from Disclosing Ethnicity | ☐ |
| Any Other | ☐ | | |

The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 gives you the right to know what information is help about you and sets out rules to make sure that this information is handled properly.

# Church Hill Surgery, Pulham Market

**Welcome to Church Hill Surgery. We would be grateful if you would spend a few minutes completing the attached Lifestyle Questionnaire. In this way we are able to quickly establish any medical needs you may have, because your medical records from your previous registered doctor may take up to 6 weeks to arrive.**

- *Are you on regular medication?*

If the answer to this is YES, you will need to make an appointment to see a Doctor and if you have a repeat prescription from your previous surgery this would be very helpful.

Name:.....

E-mail address:.....

If you are unsure of anything please speak to our Receptionists who will be very happy to help you.

## Church Hill Surgery — Lifestyle Questionnaire

Name:..... Gender: F: ☐ M:☐

Address:.....

.....

Date of Birth:..... Home Tel No:.....

Work Tel No:..... Mobile Tel No:.....

Please tick appropriate box: Married: ☐ Divorced: ☐ Single: ☐

Dependants:.....

Existence of Living Will: Yes:☐ No:☐ Details:.....

Main language spoken:.....

Employed:☐ Self Employed: ☐ Unemployed:☐ Retired: ☐

Religion.....

Housebound ☐

Alcohol (Please select one option from each of the following lines)

| **Frequency of alcohol consumption** | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
|---|---|---|---|---|---|
| **Units consumed on a typical day** | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |
| **How often do you have 6+ units** (Females) **8+ units** (Males) **on a single occasion** | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

Smoking: Never Smoked: ☐ Smoker: ☐ Ex-Smoker: ☐

Cigarettes per day: 1-6>: ☐ 7-10>: ☐ 11-20>: ☐ 20+: ☐

Weight ..... Height .....

Any specific needs .....

.....

.....

## Checked & Received by: .....

If you are on regular medication you will need to make a routine appointment with the doctor. If you have a repeat prescription from your old surgery it would be very helpful.

Present Medication.....

Allergies to Medication.....

**Chronic illness :**

Do you suffered from any of the following

Asthma ..... COPD..... Diabetes.....

Stroke ..... Heart Disease ..... Hypertension .....

Other .....

**Cervical Screening**: Date of most recent smear .....

Result: .....

**Mammogram**: Date of most recent mammogram.....

**Family History :**

Have your parents or close family suffered from any of the following (Please indicate age relative was diagnosed)

Heart Disease: ..... Stroke: .....

Cancer: .....

Diabetes: .....

Asthma: ..... COPD: .....

Hypertension: .....

Epilepsy: .....

**Next of Kin**

Name ..... Relationship:.....

Tel no: ..... Address .....

.....

**The Accessible Information Standard** aims to ensure that patients (or their carers) who have a disability or sensory loss can receive, access and understand information, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

This applies to patients and their carers who have information and / or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and / or communication needs, where appropriate.

Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

- Do you have communication needs? Yes ☐ No ☐
- Do you need a format other than standard print? Yes ☐ No ☐
- Do you have any special communication requirements? Yes ☐ No ☐
- How do you prefer to be contacted? .....
- What is your preferred method of communication? .....
- How would you like us to communicate with you? .....
- Can you explain what support would be helpful? .....
- What is the best way to send you information? .....
- What communication support could we provide for you? .....

.....

Name: ..... Date of birth: .....

If you have a carer do they need communication assistance? Yes ☐ No ☐

If 'Yes' what is your Main Carer's name: .....
Do you consent to the practice contacting your
main carer regarding your care? Yes ☐ No ☐

What is the best way to contact them?.....

Signed: ..... Date:
.....

***Please post or hand this form in to the surgery – thank you.***

Your emergency care summary

# My Summary Care Record Choice

A. Please complete in BLOCK CAPITALS

Title.....Surname / Family name.....

Forename(s).....

Address.....

Postcode ..... Phone No..... Date of birth.....

NHS Number (if known).....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name..... Your signature.....

Relationship to patient ..... Date .....

| Summary Care Record Options | Please Tick |
|---|---|
| **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had | |
| **YES** I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had **AND** any other information that I have agreed with my GP Practice to have included in my Summary Care Records<br>*Please indicate what information you would like adding if you know* | |
| **NO** I do not want a Summary Care Record | |

## What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now, with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0845 603 8510;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

# Sharing Preferences

A. Please complete in BLOCK CAPITALS

Title..... Surname/Family name.....

Forename(s).....

Address.....

Postcode ..... Phone No..... Date of birth.....

NHS Number (if known).....

B. If you are filling out this form on behalf of another person or a child, please ensure you fill out their details section A and your details in section B

Your name..... Your signature.....

Relationship to patient ..... Date .....

| Sharing out from this service | Please tick |
|---|---|
| YES I would like to make information recorded at this service sharable to other services caring for me | |
| NO I would not like to make information recorded at this service sharable to other services caring for me | |
| **Sharing in to this service** | **Please tick** |
| YES I would like this service to be able to view information recorded at other services caring for me that I have made sharable | |
| NO I would not like this service to be able to view information recorded at other services caring for me that I have made sharable | |

I have read and understood the leaflet 'Your electronic patient record and the sharing of information'

Please Note:

- Information is recorded about you at each service where you receive care and treatment.
- All information recorded about you is done so with the strictest of confidence and that any access to you electronic records is fully auditable.
- NHS staff can only access shared information if you are receiving care from them.
- Staff access is controlled with a Smart Card using 'chip and pin' security.
- You can request certain items to be marked as 'private' and these items will not be shared
- Sharing in this way is only available where services use the same computer system
- There is a difference between a Summary Care Record, which only holds limited information about you b can be viewed by any Urgent/Emergency NHS service where you need to be seen anywhere in the coun using any IT system, your Detailed Care Record, which holds all information recorded about you can onl be viewed by services that use the same computer system where you are receiving care.

# 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:** | |
| **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** | |
| | **6: Personal Identification Number** | |
| | **7: Identification number of the institution** | |
| | **8: Identification number of the card** | |
| | **9: Expiry Date** | |
| **PRC validity period** | **(a) From:** | **(b) To:** |

*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.

# 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**