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Registration Protocol

ALL NEW Patients that wish to register with the practice will need to fill

GMS1 FORM IN FULL

- TITLE
- SURNAME
- FORENAMES
- MIDDLE NAMES
- SURNAMES BY WHICH YOU HAVE BEEN KNOWN
- DATE OF ENTRY TO THE UK for ALL overseas visitors
- TOWN & COUNTRY OF BIRTH
- DATE OF BIRTH
- NHS NUMBER (Your previous GP can advise)
- HOME ADDRESS
- TELEPHONE NUMBERS
- PREVIOUS ADDRESS
- PREVIOUS GP'S NAME
- PREVIOUS ADDRESS in UK

REGISTRATION MAY BE DELAYED

All Children registering must have a family adult member registered with the practice. Where this is not the case staff must inform the Practice Manager.

Seeing some form of ID will help to ensure the correct matching of a patient to the NHS central patient registry to ensure previous medical notes are passed onto the new practice.

Patients can reasonably be asked for their NHS card but if they do not have one, then any other form of personal ID should be sufficient. The below are examples of some of the types of documentation which patients may provide:

In addition to GMS1 FORM you will need to bring one document from each of the following categories:

EVIDENCE OF IDENTITY (If available)

- PASSPORT
- PHOTO/ DRIVING LICENCE
- NATIONAL PHOTO IDENTITY CARD

EVIDENCE OF ADDRESS

- Utility bill (gas, electricity, council tax) - TV license
- Phone bill stating address - Driving License (with address)
- Credit card/Bank statement - HM Revenue & Customs statements
- Rent book or tenancy agreement. - Council Tax Bill / Rent Book
- Pension book - Home Insurance Policy
- Benefit book - Home Office permit to stay
- Bank Card
- Documentation from a reputable source, for example a letter from a voluntary Organisation, refuge, University, College Hall of Residence, Healthwatch

NB

Please be aware that these are documents that we request from all new registrants.

DRS CONFIDENTIAL FOR MEDICAL RECORDS ONLY

Name_____DOB_____

Telephone Numbers_____

Email Address_____

Next of Kin _____(Relationship)_____

Next of Kin's Contact Number_____

We may have to contact you for recalls, test results as well as to provide necessary information.

Please choose how you would like to be contacted below from the box to confirm you using the information provided above.

☐ **Telephone Number (including phone calls and text messages)**

☐ **Email**

☐ **Post**

How many adults living at the address including yourself?_____

Please list the children in your household and their dates of birth.

_____

_____

_____

Do you have a Carer/ Yes No

Name and Telephone number of Carer_____

Are you or any of your children known (if any) known to Social Services? Yes No

If yes provide the name of your Social worker together with contact details:

_____

_____

Are you are carer? Yes No

Are the people you care for registered with this Practice? Yes No

If yes provide their names together with contact details:

_____

_____

_____

Would you like to sign up for our online appointment booking? Yes No

Would you like to sign up for electronic repeat prescription services? Yes No

Name and address of the Pharmacy you would like to nominate:

_____

If you are registering a child 16 or under please bring in their REDBOOK or Immunisation Card so we can record their immunisation history for continuity.

If you wish for your Medical Records to be WITHELD from the NATIONAL SUMMARY CARE RECORDS, please ask our reception staff for a SCR opt out form.

PERSONAL HEALTH QUESTIONS

Weight:-..... Height:-.....

Allergies:-.....

Do you smoke? YES/NO

Cigarettes/Cigars/Pipe (Other).....

If yes, how many a day?.....

If you smoke how old were you when you started .....

EX-Smokers

If you used to smoke, how old were you when you started.....

If you used to smoke how many did you smoke per day.....

Passive Smoking

Are you exposed to smoke at work? Yes / No At Home? Yes /No

Smoking can seriously damage your health. Smoking Cessation Clinics are available within the Practice. If you need help/assistant to stop smoking please book an appointment with our smoking cessation advisor.

How much alcohol do you drink in 1 week/Units?.....

(1 unit equals half a pint of beer or one glass of wine or one pub measure of spirits. If you are not sure in units just write down what you actually drink in an average week)

Do you suffer or have you suffered from any of the following illnesses?

1. High blood pressure Yes/No Date of onset .....
2. Angina or Heart attack Yes/No Date of onset.....
3. Asthma Yes/No Date of onset .....
4. Diabetes Yes/No Date of onset .....
5. Epilepsy Yes/No Date of onset .....
6. Mental health problems Yes/No Date of onset.....
7. Stroke Yes / No Date of onset.....
8. Cancer Yes / No Date of onset.....
9. Depression Yes / No Date of onset.....

Do you or have you had contact with the Mental Health Services? Yes No

If yes provide the name of your Key Support Worker together with contact details:

_____

_____

Family History

Is there any of the following in your family ?

(Father, Mother, Brother, Sister) before the age of 65

Heart Disease (Heart Attacks, Angina) Yes/No

Which family member.....

Stroke? Yes/No which family member.....

Cancer Yes/No which family member .....

Site of the cancer .....

Mental Health/Depression Yes/No Which family member .....

DIET

Do you add salt to your food after cooking? Yes /No

Do you have a varied diet including milk, meat, vegetables and fruit Yes/No

All

Current Medication (Dose & Frequency)

Name of medication Strength How many times a day

.....

.....

.....

.....

Women Only

Date & Result of last cervical smear:-.....

ETHNICITY

The Government requires us to collect data about the ethnic background of our patients. This information can help the Department of Health plan to meet the needs of the community and ensure that everyone has equal access to healthcare.

Please note that we are not asking about citizenship or nationality but about the ethnic group to which you feel that you belong.

All the information we receive will be used and treated with confidence. All information released is CONFIDENTIAL and anonymous.

Completing this form is entirely voluntary. Your care at the surgery will not be affected by your decision to complete or not complete this form.

If you have any questions about completing this form, please ask a member of staff. Otherwise, please complete the from below by ticking the box of the ethnic group you feel you belong to. If you feel you are descended from more than one group, please tick the one you feel you most belong to, or choose the "Any other ethnic group" box.

AO	White	British	
BO	White	Irish	
CO	White	Any other white background	
DO	Mixed	White and Black Caribbean	
EO	Mixed	White and Black African	

FO	Mixed	White and Asian	
GO	Mixed	Any other mixed background	
HO	Asian or British Asian	Indian	
JO	Asian or British Asian	Pakistani	
KO	Asian or British Asian	Bangladeshi	
LE	Asian or British Asian	Sri Lankan	
LO	Asian or British Asian	Any other Asian background	
MO	Black	Caribbean	
NO	Black	African	
PO	Black	British	
PD	Black	Any other Black background	
RO	Other ethnic groups	Chinese	
SO	Other ethnic groups	Any other ethnic group	

Main Spoken Language:-.....

Patients Name:- _____ D.O.B:_____

We are currently screening all our newly registered patients aged 16 – 35 years regarding latent tuberculosis. Could you please answer the following questions along with your registration questionnaire:-

Primary Care Bases Screening for LTBI

Have you been out of the country/ on holiday in the last 6 months?

Which country did you visit?

Before landing in the UK which other country did you have a stop over?

When you register, you will be allocated a GP that is ultimately responsible for your care within the surgery. This does not affect, in any way at all, who you wish to make an appointment with but is just the name of the GP that you should provide should you need to be seen within secondary care. Your GP's name will be printed on the top of the purple GMS1 registration form within this pack.

Please note that completion of the registration form is not automatic confirmation of your acceptance on to the patient list. You will be contacted within 7 working days of your

application (sooner if there is a problem or query) to confirm your status and, if registered, arrange for a New Patient health Check to be carried out.

THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRE