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*

**Not all doctors are authorised to dispense medicines*

☐ 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

☐ **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

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.

39, Ashfield Road, Fordhouses,
Wolverhampton 783372.

Dr Nandanavanam's Surgery

Pendeford Health Centre
Whitburn Close, Pendeford. 780238

New Patient Questionnaire

Dear Patient,
This set of questions has been designed to help us to get to know you and your medical problems. **Please fill in the entire form or there could be delays in your registration.** All the information gathered from these questions will be handled confidentially. Your named accountable GP will be **Dr Nandanavanam**.

Surname: …… **Forenames**: ……. **Sex: M/F**

Address: ……

Post Code: …… **Tel No**: …… **Mobile No:** ……..

Email address: ……

Your Preferred Method of Contact (please circle): SMS / Telephone / Letter / Email
This is how the surgery will contact you unless in an emergency

DOB: ……/……/……. **Country of Birth**: …… **Marital Status**: ……..……

Children: Male …… Female …… **Occupation** (past & present) ……..

Place of Birth……

Have you been a member of the Armed Forces ……

Next of Kin / Emergency Contact Name: …… **Relationship to You**: ……

Tel No: …… **Address:** ……

ETHNICITY

White British	☐	Indian	☐	Black Caribbean	☐	Any Mixed Background	☐
Other White British	☐	Pakistani	☐	Black African	☐	Other Ethnic Group	☐
White Irish	☐	Chinese	☐	Black British	☐	Other	☐
White European	☐	Other Asian	☐	Other Black	☐	Patient Declined	☐

Main Spoken Language _____

Interpreter Needed: YES ☐ NO ☐

HEIGHT & WEIGHT
Do you know your Height …… & Weight ……

At this surgery we offer weight management advice. Would you in interested in speaking to our clinician for weight management advice? **YES / NO**

Dr Nandanavanam's Surgery

PRESENT ILLNESSES/TREATMENTS

Please list all illnesses you are receiving hospital treatment for:

-
-
-
-

PRESENT MEDICINES (Prescribed)

Please provide a printed list from your previous practice of any medicines or tablets you are taking at present and the illness for which you are taking them. If you require repeat medication, please provide us with either the last computer tear-off slip, showing the medication prescribed or the original containers showing the relevant information.

If you do not have a printed list, please give details of any medication you take (prescribed or otherwise):

MEDICATION

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

ALLERGIES & DISABILITIES:

Are you allergic or sensitive to any medicines, food, animals, etc.? ☐ Yes ☐ No

If yes please put what allergy you have:_____

Do you have a disability? ☐ Yes ☐ No If yes please state _____

Would you class your disability as **Slight** ☐ **Moderate** ☐ **Severe** ☐

(*Please note the answer to the above may have an impact on any future life insurance policy or private health insurance premiums*)

Do you have any communication difficulties that may require any additional assistance?
(for example: sensory loss, language barrier etc.)

If yes, please write difficulty here:

Dr Nandanavanam's Surgery

CARERS

Do you need / have anyone who looks after you or your daily needs? **Yes / No**
If "Yes", would you like them to deal with your health affairs here? **Yes / No**
(the receptionist can help with these arrangements)
What is the name and contact details of your carer? ……..……..

Do you care for anyone else? **Yes / No**
If "Yes", ask the receptionist about Carers support
What is the name of the person being cared for: ……..

THIRD PARTY CONSENT:

At this surgery we understand that communication can be difficult for some patients, or that there may be occasions where you wish for someone else to call us and obtain information from your records on your behalf such as a carer or next of kin. Due to GDPR regulations we are not permitted to give **any** information to **anyone** other than the patient unless we have written consent from the patient beforehand. If you would like to consent or get more information about Third Party Information Sharing with a Specified Person please ask at reception.

SMOKING:
Have you ever smoked? **YES ☐ / NO ☐**
Are you a current smoker? **YES ☐ / NO ☐**
If YES: Would you like to stop smoking?**: YES ☐ / NO ☐**
Cigarettes per day ……. Cigars per day …….. Ounces of tobacco per day ……..

Are you at risk of exposure to tobacco smoke? **YES ☐ / NO ☐**

DRUG USE:

Have you ever used illicit drugs? **YES ☐ / NO ☐**
If Yes, are you currently using any illicit substances? **YES ☐ / NO ☐**
If Yes, please state what type: _____
If Yes, do you wish to receive help in order to stop? **YES ☐ / NO ☐**

MEMORY:
Have you ever had concerns about your memory? **YES ☐ / NO ☐**

Dr Nandanavanam's Surgery

FEMALE PATIENTS ONLY

Date of most recent cervical smear: ……Where was this done: ……

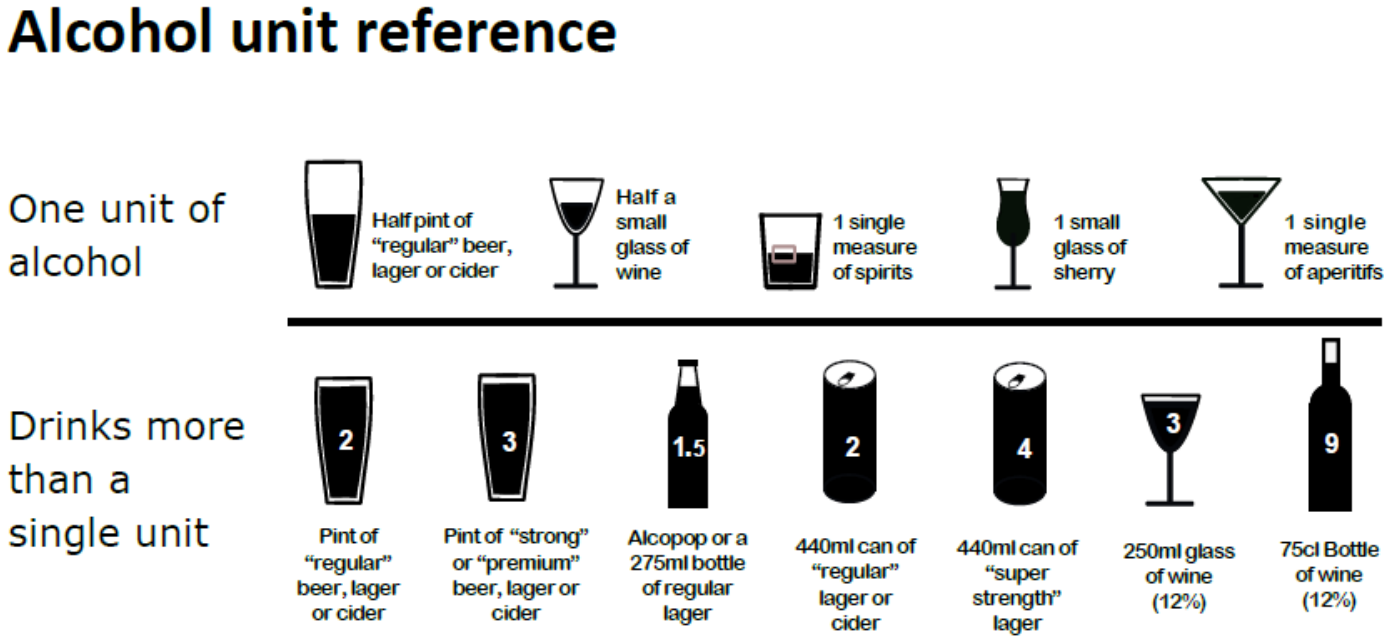
Results of most recent smear: ……

Please Note: If you do not wish to have a cervical smear please ask to sign a disclaimer which will deduct you from our recall list for 5 years

Do you use contraceptives (please tick):

- The Pill ☐
- Intra-Uterine Coil ☐ (if 'yes' please provide date due for removal: _____/_____/_____
- Diaphragm☐
- Sheath ☐
- Other Methods ☐
- Sterilized/partner had vasectomy ☐
- Not applicable ☐

Please use the below chart to help you with the next part of the questionnaire:



Dr Nandanavanam's Surgery

Alcohol use disorders identification test (AUDIT)

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

Total AUDIT score	

Would you like drink management advice? YES / NO

Dr Nandanavanam's Surgery

Patient Data Consent Form

Please read the following carefully as it will give you information about how we protect, use and share, your electronic and paper-based health record.

1. **How we protect your information within the Legislative Framework**
   The purpose for which we hold and process both personal and medical data is to assist the Practice in the provision and administration of patient care. As guardian of this information, we endeavour to follow a code of conduct which encompasses 'The Access to Medical Records Act 1990', 'The Freedom of Information Act 2000', 'The Data Protection Act 1998', 'The Common Law Duty of Confidentiality' and adhere to the NHS Code of Practice when sharing information between health professionals in support of patient care. We will **not** share or disclose your information with other 3rd parties (outside of the said purpose), unless we have your signed consent to do so.

   We ask that you consent to the information that is recorded about you, being made available to other NHS care services that care for you now and in the future for e.g. Secondary Care Services, District Nursing Services, Community Services etc.
   Please tick box to note consent: ☐

2. **Summary Care Record – your emergency care summary**
   The NHS introduced the Summary Care Record, to ensure that those caring for you in an emergency situation have enough information to treat you safely. The Summary Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had.
   Please tick box to note consent ☐

Further information can be accessed from the follow links:
www.nhs**carerecords**.nhs.uk
www.legislation.gov.uk

Please let us know if you do not want a Summary Care Record or to share your information with other NHS Services and we will provide you with an opt-out form.

3. **Messages to patient's via Text (SMS) and Email**
   The practice offers SMS Text messaging service to your mobile phone. We use this service in several ways:
   - To remind patients about their appointments
   - To ask them to contact the practice
   - To inform them on current health screening opportunities and in some cases about test results etc

   (None of these messages will contain your name)

   Due to the personal content of these messages, it is very important that you keep the Practice informed of any changes to your mobile phone number or email address.

(Please note that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed)
Please tick box to note consent ☐

4. Medical Photography Consent

To help practice staff, there may be occasions when a clinician requires a medical image to review and compare particular skin lesions. We therefore ask that you give consent for medical imaging for medical purposes only.

Please tick box to note consent ☐

Patient's Signature

I …… (Patients Name)

Give my consent for IH Medical to hold and process my personal data as noted above in the Patient Data Consent Form

Signature……. **Date**…….

Dr Nandanavanam's Surgery

PLEASE PROVIDE ID TO REGISTER FOR THIS SERVICE

Patient Online: Registration form

Access to GP online services – Over 18's Only

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):

1.	Booking appointments	☐
2.	Requesting repeat prescriptions	☐
3.	Accessing my medical record	☐

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)

1.	I have read and understand the information leaflet provided by the practice	☐
2.	I will be responsible for the security of the information I see or download	☐
3.	If I choose to share my information with anyone else, this is at my own risk	☐
4.	I will contact the practice as soon as possible if I suspect that my account has been accessed by someone else without my agreement	☐
5.	If I see information in my record that is 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:

Patient NHS Number:	Identity Verified by (initials):	Date: / /
Method of Verification: Vouching ☐ Vouching with information from record ☐ Photo ID ☐		
Authorised by (initials):	Date Account Created: / /	Date Passphrase Sent: / /
Level of record access enabled: All ☐ Prospective ☐ Retrospective ☐ Detailed Coded Record ☐ Limited Parts ☐		Reason why: